physicien and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending for use as signed by the a d be detached to been si page 2 s this After thi funeral of death. nours after death.
neral Director: A within 24 hours a To the Funeral D

Physician

/Medical

Examiner

Director

ģ

Completed

Be

Examine

Physician/Medical

Completed by

ဂ္

Medical Certification;

Funeral

Director

Worle

r then "naturel", or iteme 23a or 28e-f ehov the Medical Examiner must be notified at

Pages 1 and 2 should be filled within 72 hours after nant of Health and Mental Hygiene.
ant: If Item 27 te marked other then "naturel", or ite ury or other treumatic event, the Medical Examinal.

rtant: If its

Dep mpo any r

Physician

Examiner

/Medical

Baltimore, Maryland 21215-0036

with the Maryland

State Registrar

31. Date filed (Month, Day, Year) 01 2006

Sherer mo

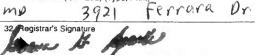
Sherer

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Jotte 12

reter



ORIGINAL

29c. License number

0 21910

29d. Date signed (Month, Day, Year)

mo

20906

Feb 26, 2006

Wheaton,

			For State Registrar	State of M	aryland / Depa <i>Cel</i>	artment of rtificate of		nd Mental H	ygiene Reg. No	UUU	08003
	Physici		Decedent's Name (First, Middle, Katio	Last) Elizabeth Re	edv			2. Date of E Month March 6	Da		3. Time of Death 5:25 P M
>	/Medic Examir		4a. Facility Name (If not institution, g	give street and number)		4b. City, Town			40	c. County of Death	
	Funeral Director				ge (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Day	r If Under 2	24 Hrs. B. Date of E Min. March		-	place (State or Foreign intry) Virginia
	sryland show		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 No
	death with the Maryland ms 23a or 28e-1 show rmust be notified at	Director	Maryland St. Mary 10e. Street and Number	r's	Hollywood	10f. Zip Code)		10g. C	itizen of What Cou	
980	after or its	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces	No No	20636 Was Decedent of Yes, specify Co	ıban, Mexican	gin? (Specify Yes or I , Puerto Rican, etc.)	-	USA 14. Race - Amer Black, White Specify: White	e, etc.
Maryland 21215-0036	l within jene. r than "	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12	Education grade completed) College (1-4or	(Give life.	dent's Usual Occ kind of work dor DO NOT use reti	upation le d <i>uring</i> most red)	of working		Kind of Business/I	,
/land	ges 1 end 2 should be filed v it of Health and Mental Hygie iff item 27 le marked other t or other traumatic event, ID	To Be C	17. Father's Name (First, Middle, La William Alexander	·				r's Name (First, Midd r P. Blevins	lle, Maide	n Sumame)	
	alth and I		19a. Informant's Name/Relationship Patsy Elizabeth Err			,		r or Rural Route Num			
Baltimore,	permit. Pages 1 end 2 Depertment of Health a Important: If Item 27 is any injury or other tra <u>once.</u>		20a. Method of Disposition 1		20b. Place of Dispo Holfywood © Nazarene Ce	httrch off a		Date arch 11, 200		Location - City or	
Balti	permit. Depertra Imports any inju		21. Signature of Funeral Service Li	win Hand	, O N	Name and Add	Gardine		me, P.	.A.	путак
Var	Physician /Medical		23a. Part1. Enter the disease, or c shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	nly one cause on each I	d the death. Do not ent	er the mode of d	ying, such as	cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Examiner	-a	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	s a consequence of): VICTOR a consequence of):	W					YEAR (
8760,	icate be executed physicien end s the burial-transit	dicai Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of):						
P.O. Box 68	the death certific y the attending p ched for use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ → € 9 □ Unknown		2 Fetal death 3	Ectopic pregnal Other (specify)			-	23d. Date of deli Month	very Day Year
	w requires that been signed by should be deta	ed by Pł	Part II. Dther significant condition	s contributing to death the contribution of th	but not resulting in the u	nderlying cause	given in Part I.		d tobacco		the cause of death?
Division of Vital Records,	The law ete has b page 2 st	Complet						24a. W au pe 1 🗆 Yes	topsy rformed?	prior to death?	topsy findings available completion of cause of 2 No
Vita	Physician: Th this certificete al director, paç	Be	25. Was case referred to medical examiner?	Hospital:)thos:	of Death (Check onl			
lon of	ling After Tuner	ition: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Inj (Month, Date)		f 28c. In	4 LINU	rsing Home 42 Re 28d. Describ			cify)
Divis	al or Attendi s after death. I Director: A od in by the fu	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed 28e. Place of In	jury - At home, farm, st tc. (Specify)	reet, factory, office	:8		(Street a Town, Sta		ral Route Number,
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the I	Medical (29a. Certifying (Check only one) 1 Certifying 2 Medical E	Physician: To the best xaminer: On the basis of and manner s	of examination and/or in	h occurred at the vestigation, in m	time, date and y opinion, deat	d place, and due to the time to the time	ne cause(e, date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier				onse number 3-7-6			ate signed (Monti	
			30. Name and address of person w	GIL	8419 ASS	Print)		1024400	>	MA	20836
7°	Sta Regist	_	31. Date filed (Month, Day, Year) MAR 0 8 20	2. Regist	rar's Signature	E.		1.00			

Howard P. Reuwer 06-1492 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item# 23a. 27.28a-f.pen/le.QS3.3/27/06 TT

Physician /Medical Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturei; or items 23a or 28e-f show any injury or other traumatic event, the Medical Ever ther must be notified at once.

Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, paga 2 should be datached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

			00	rtificate of l	Jeam			g. No.		·
 Decedent's Name (First, Middle, La 	ist)					N.	ate of Deat Ionth	Day	Year	3. Time of Death
HOWARD PHILLIP R	EUWER					Fe	bruary	y 28,	2006	4:15 P
4a. Facility Name (If not institution, given	e street and numb	per)		4b. City, Town, or	Location of D	eath		4c. Count	ty of Death	
6537 Pine Top Roa				Hurlock				Dor	cheste	er
,	Sex 7. 10∑M 2□F	. Age (In yrs. וּ	**	Months Days	If Under 24 h	Min. 8. D	ate of Birth Nonth, Day, R• 20,	Year)	Coun	lace (State or Foreitry)
212-20-1055	· • • • • • • • • • • • • • • • • • • •	74	Yrs.			API	R. 20,	1931	MARYL	AND
Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation					10	0d. Inside City Lim
ADVI AND DODGHEG	מקיי	HURL	OCK							1 □ Yes 2 🕅 N
ARYLAND DORCHES' Oe. Street and Number	LEK	HUKL	JUCK	10f. Zip Code				0g. Citizen of	f Mhat Cour	day?
	.						,,			ni y r
5537 PINE TOP ROA 1. Marital Status	12. Was Deced	ent Ever in III	S 12	216 Was Decedent of H		2 (Speedy)	You or No		USA ace - Americ	an Indian
1 ☐ Never Married 2 🔀 Married	Armed Forc	es? 10/	9- 13.	If Yes, specify Cuba	n, Mexican, Pi	uerto Ricar	n, etc.)		ack, White,	
3 Widowed 4 Divorced	1 X Yes 2 If Yes, Give Year or Date	es: 195	2	1☐ Yes 2፟No	Specify:			Spec	ify: WHI	TE
15. Decedent's E	ducation	1	16a. Dece	edent's Usual Occup	ation	17		16b. Kind of		
(Specify only highest gr	ade completed)	100 5 ()	(Give	kind of work done of DO NOT use retired	during most of	working		HEALTH		,
Elementary/Secondary (0-12)	College (1-4	+OF 5+)		ENANCE SU		OR		FACILI		
7. Father's Name (First, Middle, Las	")				18. Mother's					
LOUIS REUWER					SI	HTRLE	Y EVAI	VS.		
9a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ing Address (Street					n, State, Zip	Code)
MYRNA DAVIDSON/C	OMPANTON		1	PINE TOP				•		
Da. Method of Disposition	-11-11111011	20b. P	lace of Dispo	osition (Name of		Date		20c. Location		
1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		ate		matory or other plac OF DELMARVA		2/200	6	ET MAD	DETAI	JADF
1. Sign ture of Fundral Service Lice		CRET		2. Name and Address		2/200	0 17.	ELMAR,	DELAV	WAKE
* XDay	4 1-8	11000	ZI	ELLER FUN 06 MAIN S	ERAL HO	ME, I	0.	BOX_20	07	
23a Party. Enter the disease, or con shock, or heart failure. List on	100								<u>, MD Z</u>	Approximate
disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or	clerotic r as a consequ r as a consequ	cardic	ovascular di					monoxid	Interval Between Onset and Death le intoxica
resulting in death)	Due to (or Due to (or c.	r as a consequ	cardic uence of): uence of):						monoxid	Onset and Death
resulting in death) Sequentially list conditions, any, leading to immediate ausse. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last	Due to (or Due to (or d	r as a consequer as a	cardic uence of): uence of): uence of):		sease co			carbon 23d. D	Date of delive	Onset and Death
esulting in death) sequentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury hat initiated events esulting in death) Last FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or	ras a consequer as a	cardic	ovascular di □Ectopic pregnancy □ Other (specify)	sease co	mplica	ted by	carbon 23d. D	Date of deliver	Onset and Death le intoxica ory Day Year
esulting in death) sequentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury hat initiated events esulting in death) Last FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or	ras a consequer as a	cardic	ovascular di □Ectopic pregnancy □ Other (specify)	sease co	mplica	ted by	carbon 23d. D	Date of deliver	Onset and Death e intoxica ery Day Year
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or	ras a consequer as a	cardic	ovascular di □Ectopic pregnancy □ Other (specify)	sease co	mplica	ted by	23d. D. N. Dacco use co	Date of deliver	Onset and Death Intoxical Only Day Year The cause of death? The cause of death?
esulting in death) sequentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury hat initiated events esulting in death) Last FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or	ras a consequer as a	cardic	ovascular di □Ectopic pregnancy □ Other (specify)	sease co	mplica	23e. Did tot	23d. D. No pacco use co es 2 No en y y ned?	Date of deliver Aonth This is a second of the second of t	ony Year Day Year ably 4 Unknown under the cause of death?
esulting in death) Sequentially list conditions, any, leading to immediate ause. Enter Underlying auses (Disease or injury hat initiated events esulting in death) Last FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown art II. Other significant conditions	Due to (or	ras a consequer as a	cardic	ovascular di □Ectopic pregnancy □ Other (specify)	Sease CO	mplica	23e. Did tot 1 Ye 24a. Was a autos perforr	23d. D. No accouse constant 24by ned?	Date of deliver Aonth This is a second of the second of t	Onset and Death Intoxical Only Day Year The cause of death? The cause of death?
esulting in death) sequentially list conditions, any, leading to immediate auss. Enter Underlying lause (Disease or injury hat initiated events assulting in death) Last FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1	Due to (or Due to (or d	ras a consequence of pregnath 2 Petal nt at time of definition of the but not result to the but not result.	cardic	Dectopic pregnancy ☐ Other (specify) underlying cause give	sease co	mplica	239. Did tot 1 Yes 24a. Was a autops perforr 24 Yes 2	23d. D N Dacco use co es 2 No n 24b	Date of delivered on the state of delivered	onset and Death intoxica ony Day Year ne cause of death? ably 4 Unknot psy findings availa mpletion of cause 2 No
esulting in death) leading to immediate ause. Enter Underlying ause (Disease or injury nat initiated events esulting in death) Last FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1	Due to (or	ras a consequence of pregnath 2 Fetal nt at time of definition of the but not results to the but not results at time of the	cardic uence of): uence of): uence of): uence of): uence of): uence of): expression of the uence of th	Divascular di	en in Part I. 26. Place of	mplica Death (Ching Home	23e. Did tot 1 Yes 24a. Was a autops perform X Yes 2 ack only on	23d. D N Dacco use co as 2 No n y ned? 2 No e)	Date of delivered from the second of the sec	onset and Death le intoxica ory Day Year ne cause of death? ably 4 Unknot psy findings availa mpletion of cause 2 No
esulting in death) Sequentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury hat initiated events esulting in death) Last FFEMALE: 13b. Was decedent pregnant in the past 12 months? 1	Due to (or 1) Live birt 4 Pregnar 9 Unknow contributing to dea Hospital: 1 Ing	r as a consequence of pregnation at time of definition at time of	cardic uence of): ER/Outpatie 28b. Time of Injury	Document of the control of the contr	sease co	Death (Ching Home 28d. 1	23e. Did tot 1 Ye 24a. Was a autops perforr X Yes 2 26k only on 5 Reside Describe ho	23d. D. M. Dacco use coops 2 No no your period? 24b period? 24b period 6XDO period injury occur.	Date of deliver Anoth The probability of the second seator of the secon	ony Year Day Year Day at Scen ject repai
esulting in death) Sequentially list conditions, any, leading to immediate ause. Enter Underlying cause (Disease or injury hat initiated events esulting in death) Last FFEMALE: 33b. Was decedent pregnant in the past 12 months? 1	Due to (or	r as a consequence of as a consequence of pregnath 2 Fetal and at time of deviation of the but not result to but not res	cardical car	Discreption of the policy of t	sease co	Death (Ching Home 28d. 1	23a. Did tot 1 Yes 24a. Was a autops perform X Yes 25 Reside Describe ho	23d. D N Dacco use co Dacco use	Date of deliver Month 3 Prob D. Were autoprior to condeath? 12 Yes when (Specify urred Sub-	onset and Death le intoxica ony Day Year ne cause of death? ably 4 Unknown psy findings availa mpletion of cause 2 No y) at scen oject repairage
esulting in death) sequentially list conditions any, leading to immediate ause. Enter Underlying ause (Disease or injury hat initiated events esulting in death) Last FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant conditions 5. Was case referred to medical examiner? MXYes 2 No 7. Manner of Death 1 Natural 5 Pending 2 Accident	Due to (or	ras a consequence of pregnath 2 Fetal not at time of definition of the but not result injury. Day Year) 8 / 2006 8 / 10,ury - At hog, etc. (Specify pressure of the secure of the secu	cardic uence of):	Discoular di	sease co	Death (Ching Home 28d. L	23e. Did tot 1 Yes autops perform X Yes 2 24a. Was a autops perform X Yes 2 25c. Reside Describe ho	23d. D. No pacco use co ps 2 No py ned? 24b pompos 6200 pw injury occurrent and Num. State) 65	Date of deliver Month 3 Prob D. Were autoprior to condeath? 12 Yes when (Specify urred Sub-	ony Year Day Year Day at Scen ject repai
FFEMALE: 23b. Was case referred to medical examiner? **XXYes 2 \ No 7. Manner of Death 1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Due to (or	r as a consequence of as a consequence of pregnath 2 Fetal nt at time of definition of the but not result injury. Day Year) 8/2006 Injury - At hog, etc. (Specify arage of less of my know know know know know know know know	cardic uence of): uence of):	Divascular di	sease co	Death (Chang Home 28d. I	23a. Did tot 1 Yes 24a. Was a autops perforr 24a. Was a sudops perforr 25 Reside Describe ho 1 Mower 1 coation (St 27by or Town 1 line to the ca.	23d. D N Daacco use co as 2 No ny 24b y ance 6 NO reet and Num n, State) 65	Date of deliver Month 3 Prob D. Were autoprior to cordeath? 1 Paryes Other (Specify urred subsect gar miser or Aura 37 Pine	onset and Death le intoxica ony Day Year ne cause of death? ably 4 Unknow psy findings availa moletion of cause 2 No y) at scen oject repai age if Route Number, e Top Rd.
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No Yearning awariner? 25. Was case referred to medical examiner? 26. Was case referred to medical examiner? 27. Manner of Death 1 Natural S Pending investigation of the provided of the pro	Due to (or	ras a consequence of pregnath 2 Fetal at time of definition at time of definition at the but not result injury. B/2006 If Injury - At hoge area of my large of my known is of examination of the prest of examination of the prest of examination of each of the prest of examination of each of the prest of examination of each of the prest of examination of examination of examination of each of the prest of each of the prest of each of the prest of examination of the prest of each of the prest of	cardic uence of): uence of):	Discoular di	26. Place of art 1. 26. Place of art 4 Nursing at k? Yes 2.00 No.	Death (Chang Home 28d. I	23a. Did tot 1 Yes 24a. Was a autops perforr X Yes 25 Reside Describe ho n. mower ocation (St City or Town Lock, N tue to the cit	23d. D D D D D D D D D D D D D	oate of deliver Month antribute to the service of	onset and Death le intoxica Bry Day Year The cause of death? Bry Day 4 Unkno psy findings availa mpletion of cause 2 No y) at scen Dject repair age I Route Number, Top Rd. Bated. I the cause(s)
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Nother significant conditions 26. Was case referred to medical examiner? 27. Manner of Death 1 Natural 5 Pending investigated and investigated	Due to (or Due to	ras a consequence of pregnath 2 Fetal at time of definition at time of definition at the but not result injury. B/2006 If Injury - At hoge area of my large of my known is of examination of the prest of examination of the prest of examination of each of the prest of examination of each of the prest of examination of each of the prest of examination of examination of examination of each of the prest of each of the prest of each of the prest of examination of the prest of each of the prest of	cardic uence of): uence of):	Discoular di	en in Part I. 26. Place of er: 4 \(\text{Nursin} \) Nursin y at x? Yes 2 \(\text{No} \) No e, date and pipinion, death of enumber	Death (Chang Home 28d. I	23a. Did tot 1 Ye 24a. Was a sutops perform 24a. Was a sutops perform 25 Reside Describe ho 1 MOWET 1 OCK, Nue to the cithe time, di	23d. D N Dacco use co as 2 No n y y con	Date of deliver Month The probability of the proof to condeath? The probability of the proof th	onset and Death le intoxica any Day Year ne cause of death? ably 4 Unkno psy findings availa mpletion of cause 2 No y) at scen oject repai age if Route Number, 2 Top Rd. iated. b the cause(s) Day, Year)
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No Yearning awariner? 25. Was case referred to medical examiner? 26. Was case referred to medical examiner? 27. Manner of Death 1 Natural S Pending investigation of the provided of the pro	Due to (or Due to	ras a consequence of pregnath 2 Fetal at time of definition at time of definition at the but not result injury. B/2006 If Injury - At hoge area of my large of my known is of examination of the prest of examination of the prest of examination of each of the prest of examination of each of the prest of examination of each of the prest of examination of examination of examination of each of the prest of each of the prest of each of the prest of examination of the prest of each of the prest of	cardic uence of): uence of):	Discoular di	en in Part I. 26. Place of er: 4 \(\text{Nursin} \) Nursin y at x? Yes 2 \(\text{No} \) No e, date and pipinion, death of enumber	Death (Chang Home 28d. I	23a. Did tot 1 Ye 24a. Was a sutops perform 24a. Was a sutops perform 25 Reside Describe ho 1 MOWET 1 OCK, Nue to the cithe time, di	23d. D D D D D D D D D D D D D	Date of deliver Month The probability of the proof to condeath? The probability of the proof th	onset and Death le intoxica any Day Year ne cause of death? ably 4 Unknown psy findings availa mpletion of cause 2 No y) at scen oject repair age if Route Number, 2 Top Rd. inted. b the cause(s) Day, Year)
southistly list conditions any, leading to immediate ause. Enter Underlying ause (Disease or injury hat initiated events esulting in death) Last FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant conditions 5. Was case referred to medical examiner? MXYes 2 No 7. Manner of Death 1 Natural 5 Pending investigatic 3 Suicide 6 Could not to determined 1 Certifying P (Check only one) 1 Certifying P (Check only one)	Due to (or Due to (or C. Due to (or d	r as a consequence of pregnath 2 Fetal ht at time of definition of the but not result in	cardice continuence of): uence of): uenc	Discoular di Di	en in Part I. 26. Place of er. 4 \(\) Nursing the content of the	Death (Ching Home 28d. L. Hurrilace, and doccurred at	23a. Did tot 1 Yes 24a. Was a autops perform 24 Yes 2 25 Person of Single Properties 25 Person of Single Properties 26 Person of Single Properties 26 Person of Single Properties 26 Person of Single Properties 27 Person of Single Properties 28 Person of Single Properties 29 Person of Single Properties 20 Person of Single Properties 20 Person of Single Properties 20 Person of Single Properties 21 Person of Single Properties 22 Person of Single Properties 23 Person of Single Properties 24 Person of Single Properties 25 Person of Single Properties 26 Person of Single Properties 26 Person of Single Properties 26 Person of Single Properties 27 Person of Single Properties 28 Person of Single Properties 29 Person of Single Properties 20 Person of Single Properties 29 Person of Single Properties 20 Person of Single Properties 21 Person of Single Properties 22 Person of Single Properties 22 Person of Single Properties 22 Person of Single Properties 24 Person of Single Properties 25 Person of Single Properties 26 Person of Single Properties 26 Person of Single Properties 27 Person of Single Properties 27 Person of Single Properties 28 Person of Single Properties 29 Person of Single Properties 29 Person of Single Properties 20 Person of Single Properties 27 Person of Single Properties 27 Person of Single Properties 27 Person of Single Properties 29 Person of Single Properties 20 Pers	23d. D N Dacco use co as 2 No ny ned? 20 No e) Since 6200 reet and Num n. State) 65 D ause(s) and n ate and place 9d. Date sign arch 1	Date of deliver Month This is a series of deliver of the condition of the	onset and Death le intoxica ony Day Year ne cause of death ably 4 Unknow psy findings availa mpletion of cause 2 No y) at scer. oject repair age if Route Number, e Top Rd. tated. the cause(s) Day, Year)

State

State of Maryland / Department of Health and Mental Hygiene | 6 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** February 28, 2006 4:05A. M Loretta Mae Roberston /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Allegany Frostburg Frostburg Village Nursing Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | September 28, 1912 7. Age (In yrs. last birthday) Social Security Number Birthplace (State or Foreign
Country) **Funeral** 1 ☐ M 2 🕱 F Maryland Director 214-62-4626 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "neturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Frostburg Maryland Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21532 19300 Upper Paradise Street SW Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours efter one of Heelth and Mental Hygiene.
set if item 27 ie marked other than "neturel", or iten yn or other traumatic event, the Medical Enginem rry or other traumatic event, the Medical Enginem. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😿 No Specify: þ Specify: 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 9 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jane Ready Francis Fair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19300 Upper Paradise Street SW, Frostburg, Maryland, 21532 Judy Ravenscroft - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition March 02. 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any injury or once. Midland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) St. Josephs Catholic Cemetery 2006 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 21. Signature of Funeral Service Licensee 8 East Main St., Lonaconing, MD 21539 Part .Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis Syndrone 5 days disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, loading to infinitional cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): nding physician ause as the burial-Division of Vital Records, P.O. Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Year Month Day signed by the a 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ad vunced Dement 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24a. Was an autopsy performed Were autopsy findings available prior to completion of cause of death? 2 **X** No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation efter death. 1 🗌 Yes 2 🗆 No Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) worsochsten 00055325 Feb 28, 2006. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WONSOCK SHIN 48 Tarn Temace MD 21532 Frostburg 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 16 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2006 March MARY JANE REYNOLDS 9:48 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick 1007 Chervls Court Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, You July 31, 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) Year 1925 **Funeral** Min. Hours Months Days 1 ☐ M 2 🛱 F 200-16-9344 80 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State ir than "natural", or Itams 23a or 28a-f ehow the Medical Examiner must be notified at Yes 2□No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1007 Cheryls Court U.S.A. 21703 permit. Pages 1 and 2 should be filed within 72 hours after death v
Department of Health and Mental Hygiene
Important: If Item 27 is marked other than "natural", or Itame 23a
any hijury or other traumatic event, tra Medical Examiner meres 200. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jennie L. Knarr Vere Henry Swesey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jill Ripple / Daughter 1007 Cheryls Court, Frederick, MD 21703 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 3/8/06 Emporium, Pennsylvania Newton Cemetery 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral S 220 Name and Address of Eacility & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 nons that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or comshock or heart failure. List only Immediate Cause (Final disease or condition resulting in death) **EMIA** Pnysician wast /Medical Due to (or as a consequence of) Examiner KIDNEY Pav Sequentially list conditions, if any, leading to industrials cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or se a consequence Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month 4 Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð discor 2200 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 Yes 2V No 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 1 Yes 2 No 5 Nesidence 6 □Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 🗆 DOA this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours after To the Funaral Dirac Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and all of death (Item 23a) (Type, Print) 30. Na 2 THOUAS JC/MEN DR. State Registrar

December 19-10-1				_ FOI	epartment of Health and M Certificate of Death		ene . N. 2006	08007
Tourset Tour		Physicia	an	1. Decedent's Name (First, Middle, Last) HOWARD	CASSELL ROOP	Month	Day Year	
Carroll Congress Subset	*	/Medic	al			rebruary		1:25P M
Security		Lxamiii	e i	Longview Nursing Home	Manchester		Carroll	
Security				216-22-8948 ¹™ ^{2□} F 79 Y	hday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y Sept. 13	9. Birthp , 1926 Mar	place (State or Foreign http:) y l and
The property of the property o		yland yland					1	0d. Inside City Limits
The property of the property o		Ba-fs	ctor					
The property of the property o		with the last or 2				10g		ntry?
The property of the property o		death	nera	11. Marital Status 12. Was Decedent Ever in U.S.		ecify Yes or No-	14. Race - Americ	
The property of the property o	50	s atter		1 Never Married 2 Married 1 XYes 2 No		· mount, oto.,	016	
The property of the property o	3	2 hour	ted t	_	Decedent's Usual Occupation	16		
The property of the property o	7	rithin 7 ne. n. mer	nple	Elementary/Secondary (0-12) College (1-4or 5+)			atail aroa	ory store
Howard Clifton Roop 18a Informatis NameRelationship (Figs. Print) 18b Malling Address (Sines and Number of Plans Roops Number Clary of Your State, 20 Octob) 18a Informatis NameRelationship (Figs. Print) 18b Malling Address (Sines and Number of Plans Roops Number Clary of Your State, 20 Octob) 18a Informatis NameRelationship (Figs. Print) 18b Malling Address (Sines and Number of Plans Roops Number Clary of Your Town, State, 20 Octob) 18a Informatis NameRelationship (Figs. Print) 18b Malling Address (Sines and Number of Plans Roops Number Clary of Your Town, State, 20 Octob) 18a Informatis NameRelationship (Figs. Print) 18b Malling Address (Sines and Number of Plans Roops Number Clary of Your Town, State, 20 Octob) 18a Informatis Number of Plans Roops (Pigs. Print) 18b Malling Address (Sines and Number of Plans Roops) 18b Malling Address (Sines and Number of Plans Roops) 18b Malling Address (Sines and Number of Plans Roops) 18b Malling Address (Sines and Number of Plans Roops) 18b Malling Address (Sines and Number of Plans Roops) 18b Malling Address (Sines and Number of Plans Roops) 18b Malling Address (Sines and Number of Plans Roops) 18b Malling Address (Sines and Number of Plans Roops) 18b Malling Address (Sines and Number of Plans Roops) 18b Malling Address (Sines and Number of Plans Roops) 18b Malling Address (Sines and Number of Plans Roops) 18b Malling Address (Sines Andrews) 18b Malling Address (Sines Roops) 19b Malling	2 0	filed w Hygier ther th					· · · · · · · · · · · · · · · · · · ·	ery store
Continue School Pipe Creek Cemetery A74/2006 Inf. Linwood NID	<u>lan</u>	uld be Mental rked o	Ω	Howard Clifton Roop	Clara	Hockensm	ith	
Continue School Pipe Creek Cemetery A74/2006 Inf. Linwood NID	Mar	nd 2 sho alth and 1 27 is ma ir trauma		1.1.1				Code)
Continue School Pipe Creek Cemetery A74/2006 Inf. Linwood NID		pes 1 a of Hei		20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State 20b. Place of cemetery		1		
23a Part. Enter the disease, or conclicions that certains the disease, or conclicions that certains. Approximate of the certains Approximate of the ce	Ē	timen tunt:		'4 □Donation 5 □Other (Specify) Pipe C				MD
Physician (Middical Examinor Middical Examinor Physician Physician (Middical Examinor Physician	g	Depa Impo any i		atharise . Harler				6
Physician (Modical Examiner Modical Examiner) Part Modical Examiner Modical Exam				23a. Part1. Enter the disease, or complications that cadsed the death. Do no shock, or heart failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac of	or respiratory arres	t,	Interval Between
Securities Secur	j			disease or condition	y cirrhosis			Criset and Death
Susse. Enter Underlying or Susse. Enter Underlying or Susse. Enter Underlying a variable and the past 12 months? Susse. Enter Underlying or Susse. Enter				Due to (or as a consequence o	ge hesitic	Lailer	e	
The control of the		D 15	lner	cause. Enter Underlying	0. 10			
The control of the		xecute al-trans	xam	that initiated events c.	or effusion			
FFEMALE: 236. Was decedent pregnant in the past 12 months? 1 1 45 2 No 3 Probably 4 Unknown 1 1 45 2 No 3 Probably 4 Unknown 1 1 45 2 No 3 Probably 4 Unknown 1 1 45 2 No 3 Probably 4 Unknown 1 1 45 2 No 3 Probably 4 Unknown 25. Was case referred to medical examination and/or investigation in the past 12 months? 1 1 45 2 No 3 Probably 4 Unknown 25. Was case referred to medical examination 25. Place of Death (Check only one) 1 1 1 1 1 1 1 1 1		ite be e iysiciar ne buria		d				
9 Unknown 9 Unkn		of g	ba	IF FEMALE:			<u> </u>	
9 Unknown 9 Unkn	0	leath c attenc	clan/	in the past 12 months?				,
The state of the s	j.		hysl	9 □ Unknown 9□ Unknown				
See a seed of the completion of cause of performed? 1	ras, I	es the	þ	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		1/	
26. Place of Death (Check only one) 27. Manger of Death Natural 5 Pending investigation 28 Death Number of Rural Route Number 28 Death Number of Rural Route Number 28 Death Number of Rural Route Number 29 Death Number	ď)	lawre as bee	plet	DM type 2		autopsy	24b. Were auto	psy findings available mpletion of cause of
28a. Date of Injury at Work? Control of the Cont	<u> </u>	t: The icate h r, page		hypertension			No 1 □ Yes	2 No
1 Natural		ysiciar s certif directo	o B	examiner?				v)
WIN Starte L-Ryberg, D.O. H006 1206 2/27/06 30. Name and address of person who completed at e of death Item 23a) (Type, Print) Tracie L. Ryberg 4175 A HANONER P; KE MANCHESTER, MD. 21102		gr ff en		27. Manner of Death 1 Natural 5 □ Pending (Month, Day Year) 28b. Ti	ime of 28c. Injury at 2 jury Work?			
WIT Stack L-Ryberg, D.O. H006 1206 2/27/06 30. Name and address of person who completed at e of death Item 23a) (Type, Print) Tracie L. Ryberg 4175 A HANONER P; KE MANCHESTER, MD. 21102	NINE	or Atten after deal Director in by the	ertifica	3 Suicide 6 Could not be	m, street, factory, office			l Route Number,
WIT Stack L-Ryberg, D.O. H006 1206 2/27/06 30. Name and address of person who completed at e of death Item 23a) (Type, Print) Tracie L. Ryberg 4175 A HANONER P; KE MANCHESTER, MD. 21102	and .	Hospital 4 hours uneral sky filled		29a. Certifier (Check only Medical Examiner: On the best of my knowledge,	death occurred at the time, date and place, a	and due to the caused at the time date	se(s) and manner as si	tated.
WIT Stack L-Ryberg, D.O. H006 1206 2/27/06 30. Name and address of person who completed at e of death Item 23a) (Type, Print) Tracie L. Ryberg 4175 A HANONER P; KE MANCHESTER, MD. 21102		o the lithin 2.	Med	one) and manner stated.				
30. Name and address of person who completed as e of death Item 23a) (Type, Print) Tracle . Ryberg 4175 A HANONER P; KE MANCHESTER, MD. 21102)			Vracie L. Ruberg. D	.O. HOOG 120	6	2/27	106
of Der Grad Martin Der West		v ,		1 4 4 1	Type, Print) Tracle . By	erg MD	21100	2
Registrar MAR 0 1 2006 Marie & Angels				31. Date filed (Month, Day, Year) 32. Registrar's Signature	Annell :		·	

		-	For State Registrar	State of Ma	aryland /		artment of		and M		giene Neg. No. 0	6	8008
	Physici	an	Decedent's Name (First, Middle, JULIUS	Last)	RING	GOLI)			2. Date of Dea Month 02	Day	Year 006	3. Time of Death 6:25 A м
	/Medic Examin		4a. Facility Name (If not institution, FOREST HILL HE.		B CENTE	ER	4b. City, Town, FORES	HILL			4c. County HARF		
	Funeral Director		214-01-7990	6. Sex 7. Ag 1 X M 2 □ F	e (In yrs. last 95	birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Birth (Month Day NOV 8,	1910	Coun	lace (State or Foreign try) yland
	he Maryland 28e-f show cdiffed at	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Har 10e. Street and Number	ford	10c. City, To	own or Lo		erdeer)		10g. Citizen of		0d. Inside City Limits 1 Yes 2 No
36	be filed within 72 hours atter death with the Maryland tial Hygiene. ed other than "natural", or Items 23e or 28e-f show event, the Medical Exprintment must be indiffied at	by Funeral Director	114 Mt. Calva 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?	Ever in U.S.		Was Decedent of ff Yes, specify Cu		igin? (Spe n, Puerto			USA ce - Americ ck, White,	an Indian, etc.
21215-0036	e filed within 72 hours al Hygiene i other than "natural" vent, the Madical Ex	Completed b	15. Decedent' (Specify only highest Elementary/Secondary (0-12) 12	s Education	11	6a. Dece (Give life.	dent's Usual Occi kind of work don DO NOT use retir	e during mos ed) Ingine	er			usiness/Ind	
Maryland	should be filed nd Mental Hygid marked other umatic event,	To Be C	17. Father's Name (First, Middle, L Crawford Ringge	old				Reb	ecca	Christy	7		
	is 1 and 2 sh of Health and Item 27 is m other treum		19a. Informant's Name/Relationsh Clara Ringgold 20a. Method of Disposition 1 □ Hurial 2 □ Cremation	/ wife 3 □Removal from State	20b. Place	114 of Dispo	ng Address (Street Mt. Calv position (Name of matory or other pi femorial	ary C	hurch		Aberdee	en, M	D 21001
Baltimore,	permit. Page Department of Importent: if any injury or once.		4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L		narro		2. Name and Add	ress of Facil	ty	neral H			
	Medical Examiner	Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a Due to (or as b Due to (or as c.	ne. a consequen a consequen	ce of):	ter the mode of d			or respiratory ar	rest,		Approximate Interval Between Onset and Death
.O. Box 68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical Ex	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal de	/ eath 3[□Ectopic pregnar □ Other (specify)	су				ate of delive	ery Day Year
Records, P.	w requires that been signed by should be deta	by	Part II. Other significant conditio	ns contributing to death	but not resultir	ng in the u	underlying cause (given in Part	l.	101	Yes 2□No	3 ☐ Prob	
Vital Rec	The ate h page	e Completed	25. Was case referred to medical					26 Plac	e of Deat	24a. Was autop perfo	osy rmed? 2 No	prior to co death?	psy findings available mpletion of cause of
Division of Vi	Phys this al dir	Certification: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could r	28a. Date of Inj (Month, Di jation	ay Year)	lb. Time o	of 28c. In W	other: 42 N	ursing Ho	ome 5 Resid	dence 6 Ot	rred	al Route Number,
Divi	pitel or Attenious after deatlers deatlerel Director:	al Certifi	4 Homicide determ	g Physician: To the bes			treet, factory, office		nd place.	City or Tox	wn, State)		
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medicai		Examiner: On the basis and manner s	of examination		nvestigation, in m					, and due to	o the cause(s)
)			30. Name and address of person				, Print)	32			Fron	neg	27,200(
5		ate	DR. DAVID DUNG 31. Date filed (Month, Day, Year) MAR 0 1 2006		CPHAIL trar's Sign tur		D, BEL A	IIR, M	υ 2]	1014			
	Regist	rar	MAIL O T COOD	Lateral Bo		-							

		1	State of Maryland / Department	artment of Health and Me tificate of Death	ental Hygien	_UUU UOUU7
8°.	Physicia	n,	Decedent's Name (First, Middle, Last) Anna G. Reese			3. Time of Death 24, 2006 4:15 P M
	/Medica Examine		4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital	4b. City, Town, or Location of Death Laurel	4	dc. County of Death rince George's
	Funeral Director		5. Social Security Number 577-01-8008 6. Sex 1 □ M 2 점 F 88 Yrs.	Months Days Hours Min	B. Date of Birth (Month, Day, Yea April 10,	9. Birthplace (State or Foreign Country) 1917 West Virginia
_	Maryland a-f ahow Illed at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Low Maryland Prince George's Beltsv			10d. Inside City Limits 1 ☐ Yes 2 🖾 No
	with the	Direc	10e. Street and Number 4211 Briggs Chaney Road	10f. Zip Code 20705	10g. C	Citizen of What Country? USA
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iteme 23a or 28a-f ahow any injury or other traumatic event, its Musical Executar must be notified at once.	Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2▼No	Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Ri □ Yes 2 □ XNo Specify:	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc. Specify:White
Maryland 21215-0036	within 72 houseness.	ompieted	(Specify onfy highest grade completed) (Give life.	dent's Usual Occupation kind of work done during most of working DO NOT use retired) up Chief Operator	7	Kind of Business/Industry
and 2	be filed stal Hyg ed other event,	Be	17. Father's Name (First, Middle, Last) Joseph William Mercer	18. Mother's Name (en Sumame)
aryla	should and Mer a marke	<u>و</u>	19a. Informant's Name/Relationship (Type, Print) 19b. Mailli	ng Address (Street and Number or Rural I	Route Number, City	y or Town, State, Zip Code)
Baltimore, M	ages 1 and 2 int of Health t: If Item 27 I		1 2 Burlai 2 Cremation 3 Hemoval from State	sition (Name of Da' natory or other place) Feb	te 28,	ville, MD 20705 Location - City or Town, State tland, Maryland
Baltin	permit. P Departme Importan any injury once.		21. Signature of Funeral Service Licensee	rancas J. Collyins F OC University 21vd,	Funeral H	ome Inc
8760,	bu bu	ical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last Multiple Rib Fract Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.	ures with Complicat	tions	Interval Between Onset and Death
P.O. Box 68	The law requires that the death certificate the has been signed by the ettending physoge 2 should be detached for use as the	Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
	w requires that been signed b should be deta	2	Part II. Other significant conditions contributing to death but not resulting in the u Hypertensive Heart Disease, Atrial F			o use contribute to the cause of death? 2년No 3☐Probably 4☐Unknown
ಸಿಸಿನ್≂ ai Records,		Completed			24a. Was an autopsy performed?	
2 DB who	Phyelcian: The this certificete rat director, page	To Be	25. Was case referred to medical examiner? 1★☐ Yes 2☐ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient	26. Place of Death of them. 11 3 DOA Other: 4 Nursing Home		6 ☐Other (Specify)
A Ole pe	To the Hospital or Attending Physician: within 24 hours after death. To the Funarel Director: After this certific completely filled in by the funeral director.	Certification: To	27. Manner of Death 1	28c. Injury at Work? 7⊓ M 1 □ Yes 2X□ No eet, factory, office 28	Fell at] If Location (Street City or Town, Sta	jury occurred
Box 29	o the Hospital thin 24 hours of the Funarel impletely filled	Medical	29a. Certifier (Check only one) 18 Certifying Physician: To the best of my knowledge, deat 2 medical Examiner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, an vestigation, in my opinion, death occurred	d at the time, date a	(s) and manner as stated. and place, and due to the cause(s) Date signed (Month, Day, Year)
	with corr		30. Name an orderess of person who completed cause of death (Item 23a) (Type.	D62116	Fek	oruary 26, 2006
	State Registra	_	Meklit Workneh, M.D. 7705 Belle Point 31. Date filed (Month, Day, Year) MAR 0 1 2006 32. Registrar's Signature		MD 20770	J

			_ FOI	State of Marylar					Me	ntal Hyg	iene	000	001	10
			1 - State Registrar		Ce	rtificate	e of L	Death		Pate of Dear	eg. No.	006	Uğl	
ı	Physici	an	Decedent's Name (First, Middle, Last) REGINALD		ROSEB	v			2.	Month Feb	2 ^{Day} ,	20 [°] 0°6	3. Time	OA M
	/Medic		4a. Facility Name (If not institution, give s	treet and number)	KOSED		Town, or	Location of De	ath	100		county of Death		
E.	Examin	er	Citizens Nurs					derick				Frede	rick	
-	Funeral		5. Social Security Number 6. Sex	7. Age (in yrs.		If Under Months	1 Year Days	If Under 24 H Hours Mi	rs. 8.	Date of Birth (Month, Day)	Year)	9. Birth Cou	place (State intry)	or Foreign
	Director		5/9-64-3/34	^{M 2□ F} 57	Yrs.		,,,		D	ec 19	,19	48 Dis	t Of	Col.
	land		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation							10d. Inside	City Limits
	Mary -1 eh	to	Md Fredric	:k	Fred	rick							1 🗍 Ye	s 2∏No
	or 28e	Director	10e. Street and Number			10f. Zip	Code			1	0g. Citiz	en of What Cou	intry?	
	23a	rai	2126 Wainwri				170					U.S.A		
	iteme iteme	Funeral		2. Was Decedent Ever in L Armed Forces?		Was Deced If Yes, spec	lent of Hi of Cuba	spanic Origin? n, Mexican, Pu	(Specif erto Ric	y Yes or No- an, etc.)	1	 Race - Amer Black, White 		
39	urs aft	by F	1 Never Married	1 ☐ Yes 2 ☐ No 6 9 If Yes, Give Year or Dates:	9-/3	1 ☐ Yes 2	No No	Specify:			5	Specify: B.	lack	
ဝို	filed within 72 hours after death with the Maryland Hygiene. kther then "naturel", or iteme 23a or 28e-f ehow kther then "naturel", or iteme 23a or 28e-f ehow int, the Medical Examinat must be notified at	Completed	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usua	I Occupa	ation furing most of w	vorkina		16b. Kin	d of Business/I	ndustry	
2	ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)				furing most of w	. 3		36	1 - 7 - D	1 1-	~
2	Hygie Hygie ther ti int, th	Co	12th Grade 17. Father's Name (First, Middle, Last)		Dr	iver		18. Mother's N	ame (F	irst, Middle, i		tal Re	enab,	Inc
an	d be Bental Ked o	To Be	John M. Sco	tt				Wilh				nkins		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If Item 27 is marked other then "naturel; or Iteme 23a or 28e-f ehow empirity of other traumatic event, the Medical Examination and once.	-	19a. Informant's Name/Relationship (Typ	oe. Print(Wife)				and Number or						207
	and 2 Balth : n 27 i		Terry L. Rose					right						
Baltimore,	T Set H		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re		Place of Dispo cemetery, cre				Date			ation - City or 1		
<u>=</u>	ranen ranen ga		4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service License	//	arklaw	n Me	m Pa	ark 3/	3/0 Sno)6 l Swaen	ROCK Fur	ville	, Ma Home,	P.A.
Ba	perm Depa impo eny i		21 Signature of Pulleral Service Little Is	Summer	Se	246 N	I. W	ashing	itoi	n St 1	Rock	ville	, MD2	0850
	_		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the dea	ith. Do not en	ter the mod	e of dyin	g, such as card	ac or r	espiratory arr	est,		Approxima Interval Be	ate etween
	Physician		Immediate Cause (Final disease or condition		NTRA	CERE				RHAGE			Onset and	d Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):									
Ш	_xammer	J.	Sequentially list conditions, b	Due to (or as a conse	очелсе об.									
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,									
oʻ	te be executed ysicien and e burial-transit	Еха	resulting in death) Last	Due to (or as a conse	quence of):									
8760,		lical	d											
x 68	leath certificat attending phy I for use as thi	Physician/Med	IF FEMALE:	3c. If yes, outcome of pregr	nancy			-						
Box	atten	cian	in the past 12 months?	1 Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	al death 3	□Ectopic pr □ Other (sp					2.	3d. Date of deli Month	Day	Year
o.	that the de ned by the a deteched f	hysi	1 Yes 2 No 9 Unknown	9□ Unknown							-			
S,	8 5 8	by P	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	inderlying c	ause give	en in Part I.				e contribute to		
Vital Records,	w require been signal	ted							-	1 🗆 Y	es 2□]No 3∏Pro	bably 4	<u>J</u> Unknown
ě	elaw hesb je 2 st	Completed				-			-	24a. Was a autops perfor	sy	24b. Were au prior to death?	opsy finding ompletion of	s available cause of
a E			as W							1 ☐ Yes	2X No		2 □ No	
	Physician: r this certific ral director.	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2√€ to	ospitat: 1 ☐ Inpatient 2 [☐ FB/Outnatie	nt 3 DC	Othe	26. Place of E				☐Other (Spec	ify)	
סר	ding Phys n. After this funeral di		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		8c. Injun	/ at		d. Describe h			.,,,	
Sio	Attending r death. •ctor: After	catic	1 💢 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		, ,,,,,	М		Yes 2 □ No						
Division of	or Attendented or Attendented Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, st ify)	reet, factory	, office		281	Location (S City or Tow	treet and n, State)	Number or Ru	rai Route Nu	mber,
7	To the Hospital or Attending Physician: Within 24 hours effer death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 ☐ Certifying Phys	ician: To the best of my kr	nowledge, deal	th occurred	at the tim	ne, date and pla	ice, and	d due to the c	ause(s) a	and manner as	stated.	
/	he Ho in 24 ł he Fu pletely	Medical	(Check only 2 Medical Examir one)	er: On the basis of examin and manner stated.	nation and/or in	vestigation	, in my op	pinion, death o	curred	at the time, d	late and I	place, and due	to the cause	(s)
	To the twithin 2	Σ	29b. Signature and title of contifier	Pools				number	,	2	9d. Date	signed (Month	, Day, Year)	
•	7		X My X	(Colsus			リー	1397				4271	06	
			30. Name and ddress of person who co Dr Robert L.	mp to cau of death (Ite Kaufinian	sm 23a) (Type, 300 W •		St	reet,	$\operatorname{\mathtt{Fr}}_{\epsilon}$	drick	, M	d #217	702	
	Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sign		all p					•	,,		
	Registr	ar	MAR 01 200	6										

1			For State Registrar	State o	f Marylar		artmer <i>rtifica</i> i					giene Reg. No.	06	08011
	Physic /Medi		1. Decedent's Name (First, Mid		um	00D					2. Date of De Month		Year 2006	3. Time of Death 10:25 A M
	Exami		4a. Facility Name (If not instituti	on, give street and nu	mber)				Location	of Death	111111111111111111111111111111111111111	4c. Cour	ity of Death	1
			5. Social Security Number	MEDICAL CEN	7. Age (In yrs.	last hirthday	-	NAPOI r 1 Year	LIS If Under	24 Hrs	8. Date of Bir		E ARUI	
	Funeral Director		579-46-7566	1 M 2 X F	69	Yrs.	Months		Hours	Min.	Month, Da	ıy, Year)	9. Birti Coi DC	place (State or Foreign intry)
	land land		Usual Residence of Decedent 10a. State 10b. Count	ly	10c. Cit	ty, Town or Lo	ocation							10d. fnside City Limits
	Marylan 1-1 show Ified at	tor	MD OUEE	N ANNE'S	GR	RASONVI	LLF							1 □Yes 2 No
	or 284	Oire	10e. Street and Number		, 01	21001111		p Code				10g. Citizen o	f What Cou	intry?
	ath w	rai	833 OYSTER COV					1638				USA		
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland Fleath and Mental Hygiene. If the the marked other then "naturel", or Items 23 a or 28a-f show other traumatic event, the Macical Examinar must be nutified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ▼ Ma 3 □ Widowed 4 □ Divorce	Armed Fo	2 X No ve		Was Dece if Yes, spe 1 Yes	crfy Cuba	spanic Or n, Mexica Specify	n, Puerto I	ecify Yes or No Rican, etc.)	В	ace - Amer fack, White	
21215-0036	within 72 h ene. then "natu ne Medicel	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	ent's Education est grade completed)	1.40(5.1)		dent's Usu kind of wo DO NOT u	rk done a	luring mos	st of workii	ng	16b. Kind of	Business/l	ndustry
21	filed witl Hygiene ther the	le S	12	College (1-401 5+)	SALE	SMAN					AUTOM	OBILE	:
Maryland	2 should be filed withir and Mental Hygiene. Is marked other then surnatic event, ILE MS	Be	17. Father's Name (First, Middle								(First, Middle,	Maiden Sum:	ame)	
ryla	should be ind Mental I	2	JOHN SMAL 19a. Informant's Name/Relation			10h Maili	0-1-1	(Ct		L. P				
Ma	nd 2 s lith an 27 le i		MICHELE SMALLW								GRASON			
ē,	s 1 and 2 of Health Item 27 other tra		20a. Method of Disposition		20b. F	Place of Dispo	sition (Na	me of	1		ate	20c. Location		1638 own, State
E I	8 2 = 5		1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other (State CHE	SAPEAK TER, L	E CRE	MATI	ON	3/01	/2006	STEVE	ттури	LE, MD
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service	e Licensee	Mu		LLOWS	S. HE	s of Facili	b BETN		AM FIINE		IOME, P.A.
1			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that of	aused the deat	h. Do not ent	er the mod	de of dying	, such as	cardiac o	r respiratory ai	rrest,	1017	Approximate Interval Between
68760,	Physician /Medical Examiner but sicien and pulsarician and sthe pnijar-transit	edical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	or as a consequence or a consequence	uence of):	NY		Ge		Dis	614IE		
.O. Box	The law requires that the death certifica tte has been signed by the attending ph tage 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		inth 2 ☐ Feta ant at time of d	Ideath 3	Ectopic pr						ate of deliv	ery Day Year
S, D	es that gned b	by Pi	Part fl. Other significant condit	ions contributing to de	eath but not res	ulting in the u	nderlying c	ause give	n in Part I		23e. Did to	obacco use co	ntribute to t	he cause of death?
ord	w require been signature		DVT, PV	Monde	m Eu	BOL	15M				101	es 2□No	3 🗌 Prol	bably 4 Unknown
al Records,		Completed									24a. Was autop perfo 1 \(\text{Yes} \)		Were auto prior to co death? 1 \(\subseteq Yes	opsy findings available impletion of cause of
of Vital	<u>a</u> 8 9	o Be	25. Was case referred to medical examiner? 1 Yes 2.270	Hospitaf		50.0	1	Othe			(Check only o			
1 of		n: To	27. Manner of Death	28a. Date o	of Injury	ER/Outpatien 28b. Time of		8c. Injury	at Nu	7	ne 5 ☐ Resid			(y)
ior	Attending I r death. actor: Alter by the tuner	atio	1 ☐ Natūral 5 ☐ Pendi 2 ☐ Accident invest	igation (Mont	h, Day Year)	Injury	М	Work′ 1 □ Y	? es 2 □	No				
Division	- 0	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	nined 286. Place	of fnjury - At ho ng, etc. (Specif)	ome, farm, str	eet, factory	, office		2	8f. Location (S City or Tox	Street and Num in, State)	ber or Rur	al Route Number,
	To the Hospital o within 24 hours af To the Funeral Di completely filled in	edicai	29a. Certifier (Check only one) 2 Medical	ng Physician: To the I Examiner: On the ba and mann	isis of examina	wledge, death tion and/or in:	occurred estigation,	at the time in my opi	e, date an inion, dea	d place, as th occurre	nd due to the o	cause(s) and n date and place	nanner as s , and due t	stated. o the cause(s)
	To To	Σ	29b. Signature and title of certific	7				. License				29d. Date sign		
•			1.18 and	W-			J	741	09	8		03/	01/	2006
			30. Name and address of person	who completed cause		116 D	Print)	√3€	Lw	, th	NO 1	horses	. 21.5 A	2006
	Sta Registr		31. Date filed (Month, Day, Year		egistra s Signa	ture	Son	le le	,	/	ر ب		43/11	- ()

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 945A M **Physician** 2006 03 03 breita /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Riverview Care Center Essex If Under 1 Year | If Under 24 Hrs. | Months Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months 1 □ M 2 1 1 × E 233-56-7718 92 5/3/1913 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show treumatic event, the Medical Examiner must be notified at 1 XYes 2 ☐ No Baltimore Essex MD Director 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number ö 1 Eastern Blvd. 21221 U.S. 238 death by Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after ☐Yes 2 No 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 XWidowed 4 □ Divorced Year or Dates: "naturaf" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) other than Elementary/Secondary (0-12) Sewing factory Seamstress 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) perrait. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any injury or other treumatic event QDCs. Be Anna Fickey Helmick Burley Helmick 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11 N. Bradford Street, Baltimore, MD 21224 Bonnie Meekins 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 3/8/2006 Terra Alta Cemetery Terra Alta, 22. Name and Address of Facility Arthur H. Wright Funeral Home 105 Highland Avenue, Terra Alta, WV 26764 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Coman V Mcobilly Heteriosclewie Immediate Cause (Final 14 Del tusiu Physician 4200 disease or condition resulting in death) /Medical Due * (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of): Examiner burial-transit The law requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 4□Pregnant at time of death 1 ☐ Yes 2 ☐ No detached O. 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, been signe should be d Completed by 1 Yes 2 No 3 Probably 4 TUNKnown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an achies mus autopsy performed? 1 ☐ Yes 2 ☐ No 2 100 certificate Durke Division of Vital or Attending Physicien: 25. Was case referred to medical 26. Place of Death Check onl one Be examiner' Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA ٩ 1 ☐ Yes 2 ☐ No 1 Inpatient this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending 1 🗌 Yes 2 No death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) á 4 Homicide filled in To the Hospitel within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific D19667 03-04, 200 6 Chrome 5 wife 608 6/on Bernie , 2/06/ w 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Sigwart Z 19hWA 1310 ichae 1 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 116 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yeer **Physician** ROBERT SANFORD SCHROEN SR. February 26,2006 6:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13634 Glisson Mill Road Mount Airv Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 28,1958 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 10XM 2□ F Yrs 47 Maryland Director 215-74-5089 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits rthen "naturel", or items 23s or 28e-f shov tre Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Frederick Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13634 Glisson Mill Rd. 21771 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) 2 Elementary/Secondary (0-12) other then Cook Restaurants Dearmit, Pages 1 and 2 should be files.
Department of Health and Mental Hygic Importent: If tem 27 is marked eny injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles William Schroen Nancy Marie Sanford 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13634 Glisson Mill Rd. / Mt. Airy, MD Mona Lisa Schroen / Wife 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Prospect Cemetery March 2,2006 Mount Airy, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Stauffer Funeral Homes, P.A. eler 8 E. Ridgeville Blvd./ Mount Airy, MD 21771 saymond 23a. Part 1. 55 r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SCHEAUC **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physicien and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical attending p 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death signed by the at d be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Knknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1□ Yes 2ØNo To the Hospitel or Attending Physician: funeral director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of After 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident ŧ, 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Light Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amegashie, MD / 915 Toll House Ave. # 307 / Frederick, Maryland 21701 Ernest 32. gistrar's Signature State 2006 Registrar

			1 - For State Registrar	State of	Maryland		artment of H		Mental Hy	giene Reg. No.	006	080	
	8 jul 19 18 1		1. Decedent's Name (First, Middle,	Last)					2. Date of De	ath		3. Time of [Death
.~	Physici /Medio		Louis John Sach	er, Jr.					Februa	ry 24	2006	5:20	A^{M}
	Examir		4a. Facility Name (If not institution, g		ber)		4b. City, Town, or	Location of Dea	ath	4c. 0	County of Death		
			Crofton Convale	scent Cen	ter		Crofton			An	ine Arun	ide1	
y	Funeral		Social Security Number 6	.Sex 7 1 X XM 2□F	. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hr Hours Mir		rth ay, Year)	9. Birth	place (State or	Foreign
	Director	9	235-22-0133	WALTEN ZUF	85	Yrs.			08/22/	1920		: Űirgir	ıia
- 30	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	cation					10d. Inside City	v Limits
	Aaryli F sho	ō		0	D							1 🛣 Yes	
	28a-	Director	Maryland Prince	Georges	Bowi	.e	10f. Zip Code			10a Citiz	en of What Cou	intry?	
	with Sa or		12309 Manvel La	n .o			20715			USA	011 01 11111111 000	y.	
	Jeath ms 23	Funeral	11. Marital Status	12. Was Deced	lent Ever in U.S	S. 13. V	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Specify Yes or No		4. Race - Amer	ican Indian,	
က	or iter	표	1 ☐ Never Married 200 Married	Armed Ford	2 No				into Rican, etc.)	į	Black, White	, etc.	
ğ	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ther than madical Examinar must be redified at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dat	les: 1942-	• 45	1□Yes ŽOXNo	Specify:			Specify: Whi	.te	
2-0	72 hc	Completed	15. Decedent's (Specify only highest			16a. Deced	dent's Usual Occupa	ation during most of w	orkina		d of Business/Ir		
21215-0036	ithin Ban *	npl	Elementary/Secondary (0-12)	College (1-	4or 5+)	life. I	DO NOT use retired	0			ral Ene		
2	led w lygier her th		47 Fabrical Name (First Middle 1	4		Engi	neer	40 14 11 1 11		-	latory	Commiss	310n
and	9 - 2 >	Be	17. Father's Name (First, Middle, La						ame (First, Middle	, Maiden S	iumame)		
Maryland	2 should be filed within 72 hours after death with the Marylan and Mental Hygene. is marked other than "natural", or items 23e or 28e-f show aumatic event, the Madical Examinar interest be inclified at	2	Louis John Sach 19a. Informant's Name/Relationship			10b Mailie	ng Address (Street a		. Fulton	or City or	Tour State 7	in Code l	
<u>≅</u>	d 2 s th an th an traul		Virginia H. Sac				9 Manvel			-		p Code)	
စ်	es 1 and 2 should b of Health and Ment fitem 27 is marked r other traumatic e		20a. Method of Disposition	HEL/ WIIC	20b. Pla	ace of Dispo	sition (Name of		Date		ation - City or T	own, State	
altimore,	Pages nent of I ant: if its ury or o		XXBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		tate Cer	Mary. Crer	natory or other plac Land	00/	20/2006	0		MD	
≣	permit. Page Department of Important: if eny injury or once.	. "	21. Signature of Funeral Service Lice		vec	erans	Cemetery Name and Addres	ss of FacilityR	28/2006 bert F	Grow	Funera	1 Home	_
m		V. 3	1/2dt	-			6000 Anna					II HOME	
***	*		23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that car	used the death.	Do not ent	er the mode of dying	g, such as cardi	ac or respiratory a	rrest,		Approximate Interval Betw	reen
	Physician		Immediate Cause (Final disease or condition	(6	N MAN M	010	Artons	1)12	com.			Onset and De	eath
9.50	/Medical Examiner		resulting in death)	Due to (o	r as a conseque	ence (t):	1, 1	^	7				
	Examine	_	Sequentially list conditions,	b. T.4	euje	all	Vasci	Wal	01800	W-			
	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due ito (o	ras a conseque	ence of):							
	be executed sician and burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c	r as a conseque	ence of):							
8760	cate be executed chysician and the burial-transit	aiE	(·								
687		edicai		O									
Box	attending for use as	Z.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnan		-			23	3d. Date of deliv	very	
	The law requires thet the death certificate has been signed by the attending lagge 2 should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregna	th 2 □ Fetalo nt at time of dea]Ectopic pregnancy] Other (s <i>pecify)</i>				Month	Day Ye	ear .
о. О	res thet the de signed by the a be detached f	hys	9 Unknown	9□ Unknov	wn								
	gned goede	by F	Part II. Dther significant conditions	contributing to dea	th but not resul	ting in the ur	nderlying cause give	en in Part I.	23e. Did	obacco us	e contribute to	the cause of de	ath?
ğ	w require been si should t							-	10	Yes 2	No 3□Pro	bably 4 □Ur	nknown
Records,	law r las be	Completed							24a. Was		24b. Were auto prior to co	opsy findings av	vailable use of
		Con							perfo 1 ☐ Yes	ormed? 2.⊠√√o	death? 1 ☐ Yes		
Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				1		eath (Check only	one)			
0	Physician: r this certifica ral director, p	ပ္	1 Yes 2 No	Hospital: 1 □ Inj		R/Outpatien		4 Ly prursing	Home 5 ☐ Res			fy)	
ב	ing After une	ion	27. Manner of Death 1 Natural 5 ☐ Pending		Day Year)	28b. Time of Injury	Work		28d. Describe	how injury	occurred		
Division	eat or:	icat	2 Accident investigat 3 Suicide 6 Could not	be On Direct	of Injury - At hor	ne farm etr	eet, factory, office	Yes 2□No	28f Location (Street and	Number or Rur	al Pouto Numb	
2	i or Attend after death Director:	Certification:	4 ☐ Homicide determine	building	g, etc. (Specify)	10, 141111, 3(1)	eet, factory, office		City or To		Number of Hur	ar noute world	θ1,
	ospita hours ineral y filled		29a. Certifier Certifying	Physician: To the b	est of my know	ledge, death	occurred at the tim	ne, date and place	ce, and due to the	cause(s) a	and manner as	stated.	
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by i	Medical	(Check only one) 2 Medical Ex	aminer: On the bas and manne	sis of examination of stated.	on and/or inv	estigation, in my of	oinion, death occ	curred at the time,	date and p	place, and due t	to the cause(s)	
	To t	Σ	29b. Signature and vittle of certifier				29c. License	number	0	29d. Date	signed (Month,	Day, Year)	
1			1///				D	D 102	0-	$\bigcirc 2$	-24-	06	
			30. Name and address of person wh	o completed cause	of death (Item	23a) (Type,	Print)	1.11			Nan: : c	Y. C =	2114
			31. Date filed (Month, Day, Year)	122 02	Strar's Signatu	10 KJ	LUELY /	IVESTE	EZ31 A	ININI	Truus	MV. 2	1401
	Sta Registr		FEB 2 8		nstrar s Signatu	M .	Land.						
198	3,5,1	43	1 20 % 0	2000		N. A							

			1 - State Registrar 1. Decedent's Name (First, Middle, Las	St)	Ce	ertificate of	Death	Re 2. Date of Death	g. No.	3. Time of Death
	Physici		Dooley	Stephano	s			Month February	Day Y	ear 006 8:30 A M
)	/Medi Examir		4a. Facility Name (If not institution, give		· L	4b. City, Town, o	r Location of Death		4c. County of	
			10347 Champions W	ay		Laurel			Howa	ırd
	Funeral Director		5. Social Security Number 6. S 579–40–1392 Usual Residence of Decedent	ex	'In yrs. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 8–27–19)	Year) 32 V	B. Birthplace (State or Foreign Country) Nashington, DC
	ow m		10a. State 10b. County	1	Oc. City, Town or I	_ocation				10d. Inside City Limits
:	Mary Find Sh	į	Maryland Worcest	er	Oce	an Pines				1 ☐ Yes 2 No
4	or 28	Jrec	10e. Street and Number		,	10f. Zip Code		10	g. Citizen of Wh	at Country?
	23a	rai	1 Brush Island C			218			USA	
	init. Pages 1 and 2 should be filed within 72 hours after death with the maryland afternor of Health and Mental Hyglene. afternor of Health and Mental Hyglene. afternor of them 27 is marked other than "natural", or items 23a or 28e-f show injury or other traumatic event, the Medical Examinar most be notified at a page.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:	er in U.S. 13	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No		ecify Yes or No- Rican, etc.)		American Indian, White, etc. White
9	natu	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dec	edent's Usual Occup	ation during most of work	ina 1	6b. Kind of Busi	ness/Industry
	ha.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	e kind of work done of DO NOT use retired				
1	Hygie thert nt, in	ပို	12th 17. Father's Name (First, Middle, Last)			Homemake		e (First, Middle, M		ome
	Med o	To Be	Thomas	Stephanos			Thespi		Karapand	lilakis
1	nd Men rmarke	-	19a. Informant's Name/Relationship (7	-	19b. Mai	ling Address (Street				
7	and 2 saith a n 27 is		Eva Tuck/ Daught	er	314	2 Stoneher	nge Drive	, Riva, M	Maryland	21140
	r oth	1	20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐	Damoval from State	20b. Place of Disc					ty or Town, State
	ment ant: I		4 Donation 5 Other (Specify			rematory		8–06		er,Maryland
	Department of the important: If its any injury or of once.		21. Signature of Funeral Service Licen	S00						neral Home
	10 % # O	\vdash	220 Part Leter the disease or com-	-liantions that sound th						, MD 21037
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	le death. Do not e	nter the mode of dyin	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	a		luen t	znicune			3 645
	xaminer			Due to (or as a o	consequence of):	THEY CA	norn			7 -0
		Jer	Secuentially list nanditions if any, leading to immediate cause. Enter Underlying	Due to (or as a c		117/0 011				1 300
	incate be executed ig physicien and as the burial-transit	edicai Examiner	that initiated events	C	1112	HIBCO O	Rnon k	Lan O	FULL	us
	ie exe	EX	resulting in death) Last	Due to (or as a c	consequence of):					
	physic the b	dica		. d.						
1	ding p		IF FEMALE:	23c. If yes, outcome of	pregnancy				201.0	. A a l'
the death	ine raviequies inatine dealincenste has been signed by the ettendin page 2 should be detached for use	by Physician/N	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	1 Live birth 2 4 Pregnant at tin	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Month	,
40.00	s been signed to should be dete		Part II. Other significant conditions of	ontributing to death but i	not resulting in the	underlying cause give	en in Part I.			ute to the cause of death?
	s uee pinou	Completed					-	1 Yes	2 ∑ No 3	☐ Probably 4 ☐Unknown
The least state of	has b	nple						24a. Was an autopsy	prie	ore autopsy findings available or to completion of cause of
	cate							perform 1 Yes 2		ath?]Yes 2□ No
Ob. soloine	certifi	Be	25. Was case referred to medical examiner?	Hospital:		ont 3 DOA Oth		h Check only one		Daughter
-	rthis raldi	<u>۲</u>	1 ☐ Yes 2 XNo 27. Manner of Death	1 Inpatient	2 ER/Outpatie	SIL SU DOA	4 Nursing no	me 5 Resider		
Constitution of the consti	r death. ector: After by the fune	igi	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	(e <i>ar</i>) Injury	Worl	k? Yes 2 □ No		milety coodinoc	•
ď	efter dea Director	Certification:	3 Suicide 6 Could not be determined		- At home, farm, s (Specify)	treet, factory, office		28f. Location (Stre City or Town,	et and Number State)	or Rural Route Number,
	within 24 hours eiter death within 24 hours eiter death and 124 hours eiter death and 124 hours eiter death completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 X Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of r niner: On the basis of en and manner state	kamination and/or i	ith occurred at the tin nvestigation, in my o	ne, date and place, pinion, death occurr	and due to the cau	use(s) and manr e and place, an	per as stated. d due to the cause(s)
	withir To th	M	29b. Signature and title of certifier	Scho	-gys	29c. License D17				Month, Day, Year) 27, 2006
			30. Name and address of person who		th (Item 23a) (Type	, Print)				
			Stanley A. Schwar			edical Par	k Dr. Si	ilver Spr	ing,MD	20902
	Sta		31. Date filed (Month, Day, Year) FEB 2 8 2	32. Pagistrar's	Signature	hard .				
7L14	Registr		FED & 0 Z	UUU -	J. J.					
· irVl	/ PSeV 1/2	AU I								

DHMH 17 Rev 1/2001

		•	Amend Item State Registrar	9 pateterpholy	941/1417	d†Pope Cei	inmeni tificate	t of H	ealth a	and M		giene Reg. No:	006	080	6
0	Physicia	an	1. Decedent's Name (First, Middle, L	ast)							2. Date of De. Month	Day	Year	3. Time of	
	/Medic	al	Ethel Virginia S				4h Cilv	Town or	Location of	of Death	Februa		2, 2006		РМ
1	Examin	er	Larkin Chase Nur				Bow		Location	or Bouilt			ince Ge		
	Funeral	-		Sex 7. Ag	ge (In yrs.	last birthday)	If Under Months	1 Year	If Under	24 Hrs. Min.	8. Date of Birt (Month, Da	th	9. Birth	place (State o	r Foreign
şe.	Director		212-09-5487 Usual Residence of Decedent	1 □ M 2 X F	96	Yrs.					09/30/	1909	MD Cor		
	/land		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside Ci	ty Limits
	e-feb	ctor	Maryland Prince	George's	Boy	wie								1 X Yes	2 🗌 No
	or 28	Funeral Directo	10e. Street and Number				10f. Zip					•	n of What Cou	intry?	
	eath v	eral	2814 Belair Road	12. Was Decedent	Ever in U	S 13 1	207		spanic Ori	gin? (Spe	ecify Yes or No	USA - 14	. Race - Amer	ican Indian.	
(0	ifter d	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces'	?						ecity Yes or No Rican, etc.)		Black, White		
993	72 hours after death with the Maryland natural', or Items 23a or 28e-f ehow disal Examiner must be natified at	d by	XXWidowed 4 □ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes }	ALA NO	Specify:			S	pecify: Wh	ite	
21215-0036	n 72 h	Completed	15. Decedent's (Specify only highest g			16a. Deced (Give	dent's Usua kind of wor DO NOT us	rk done a	<i>furing</i> mosi	t of worki	ng	16b. Kind	f of Business/li	ndustry	
212	e filed within at Hygiene. I other then "	ошо	Elementary/Secondary (0-12)	Coflege (1-4or	5+)	Beaut						Se1	f Emplo	yed	
nd	be filed within 72 hours after death with the Marylan ital Hygiene. Ind other then "natural", or items 23s or 28e-f show event, the Madical Examinar must be multiled at	Bec	17. Father's Name (First, Middle, Las	st)					18. Mothe	er's Name	(First, Middle,	Maiden S	umame)		
yla	should be and Mental marked o	P	Carroll Maddox			T					roy Ri		- 0 - 7		
Maryland	d2 tha thau		19a. Informant's Name/Refationship Patricia Prieste		r		-				owie, Numbe			p Code)	
	is 1 and of Health Item 27 other to	()	20a. Method of Disposition	- YES	20b. P	Place of Disponentery, crer					ate		ation - City or T	own, State	
m 0	Page nent o ant: If ury or		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec							2/28	/2006	Suit	land, M	D	
Baltimore,	permit. Pages 'Department of H Importent: If Ite eny Injury or ot		21. Signature of Funeral Service Lic	ensee		22	2. Name an	d Addres	s of Facilit	y Rob	ert E.	Evans	s Funer	al Hom	e
4 1	0 0 E ● 0		23a. Part1. Enter the disease, or co	mplications that cause	d the deat						ad Bow		20/15	Approximat	
	Dharida		shock, or heart failure. List on Immediate Cause (Final	y one cause on each	ine.			o or dying	M	\	in respiratory a	11031,		Interval Bet Onset and	ween
	Physician /Medical		disease or condition resulting in death)	Due to (or as	a conseq	uence of):	7		July	عد ١				MONT	/
W.	Examiner		Sequentially list conditions.	b. DEMO.	ALD	E	-d-	MA	2					yni	
	ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	uerfce of):		,							
	axecut	xan	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a conseq	uence of):									
8760,	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	cal		d											
9	artifica ing ph		IF FEMALE:												
Вох	eath certific attending p	Physiclan/Med	23b. Was decedent pregnant in the past 12 menths?	23c. If yes, outcome 1☐Live birth 4☐Pregnant a	2 Feta	Ideath 3□	Ectopic pr					23	 d. Date of defined Month 	-	Year
P.O.	the de y the a	ysic	1 □ Yes 2 No 9 □ Unknown	9□ Unknown	it time or a	ealli 5	Other (sp	о спу)							
	res that the de signed by the a be detached f	by Pi	Part II. Other significant conditions	contributing to death I	out not res	ulting in the u	nderlying c	ause give	n in Part f		23e. Did t	obacco use	e contribute to	the cause of c	leath?
ord	v require been sig should b		Acute of Chi	Lonic Cen	٠	fails	re ,	DLD	bete	\$	1 []	Yes 2	No 3□Pro	babíy 🔼	Jnknown
Division of Vital Records,	e law n has b	Completed	type 2								24a. Was autoj	psy	24b. Were aut prior to o death?	opsy findings ompletion of c	available ause of
alF	Th ete pag	e Col	25. Was case referred to medical								1 Tes	rmed?	1 🗆 Yes	2 No	
\equiv	Physician: r this certific ral director,	To Be	examiner?	Hospitaf: 1 ☐ Inpati	ent 2 🗆	ER/Outpatier	nt 3 DO	Othe			n <i>(Check only o</i> me 5 ☐ Resi		☐Other (Spec	ify)	
D 0	ng Ph fter th neral		27. Manner of Death Natural 5 Pending	28a. Date of Inj (Month, Da	ury ay Year)	28b. Time o	f 2	8c. Injury Work			28d. Describe				
isio	Attending in death.	icat	2 Accident investigati	be One Blace of le	ium. At he	amo form at	M		Yes 2 🗌		28f. Location (Stroot and	Number or Ru	m I Pouto Num	hor
Div	after after Direct	Certification:	4 Homicide determine	28e. Place of In building, e	tc. (Specif	y)	eet, ractory	, onice		1	City or To		ivaniber of Au	ai noute ivuii.	Der,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier Check only, 2 Medical Ex	Physician: To the best aminer: On the basis	of my kno	wledge, deat	n occurred	at the tim	ne, date an	nd place,	and due to the	cause(s) a	nd manner as	stated.	
	the H hin 24 the F mplete	Medicai	one)	and manner s	ated.	non and on m		. License		IIII OCCUII	ed at the time,				
	To To Cor		29b. Signature and title of certifier	1 un		MA	7)(27.6	1			signed (Month		6
			30. Name and address of person wh	o completed cause of	death (Item	23a) (Type,	Print)	11							
			Richard J. Rel	dam, in		100	Arra	Noc:	1 2	*	carhe	- m	n 20	701	
	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 8	2006 32. Regist	rar's Signa	ture	April	E.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 7:10 PM James Henry Smith 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hospital
7. Age (In yrs. last birthday) rosedale altimore **x**auare ankliv ff Under 1 Year | ff Under 24 Hrs. 8. Date of Birth (Month, Day, Y June 24, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Year) 1X M 2 ☐ F 212-38-4438 64 Yrs. 1941 Mass. Director Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. fnside City Limits rthan "natural", or Itema 23e or 28a-fahoi tre Medical Examinarmat be notified at 1 XYes 2 □ No Director MD Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2029 Armstrong Street 21040 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 25No Specify: Specify: White Baltimore, Maryland 21215-003 þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Laborer Factory 7 is marked other traumatic avant. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Henry Smith Ann Franzen ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Dawn Montgomery (Daughter) 7146 Harlan Lane Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State = 0 4 Donation 5 Other (Specify) R. A. Ferris & Co. 3/10/06 West Chester, PA permit.
Deporting Importe any inju 21. Signature of Funeral Service Licensee Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** neumonia piration 4 days /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Cancer attending physician and for use as the burial-transit onchogenic The law requires that the death certificate be executed 16 months von-Omall Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) certificete has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Ves 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 **N**0 1 ☐ Yes 2 ☐ No director Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Medical Certification: To this After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 Yes 2 No within 24 hours after death.

To the Funeral Director: /
completely filled in by the f 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the h 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Illian P. M. Sucre Res D16801 03 08 2006

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

900 Franklin Sq. Drive Baltimose Maryland
32. Asgistrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 1 5 2006

32. sgistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 6 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Feb. 27 Terrance Schubring 2006 9:30 A M /Medical 4a. Fecifity Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Heritage Harbour Health Center Annapolis Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 5, 19 5. Social Security Number 9. Birthplace (State or Foreign Country) Wisconsin 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 F Yrs. Director 389-38-6834 65 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28a-f show other freumatic event. In Medical Examplement the rollined at 1 XYes 2 □ No Director MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3113 Twig Lane 20715 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □X/es 2 □ No If Yes, Give Year or Dates: 1959–67 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or fler any injury or other treumatic event. If a Marital Exerting ORS. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) News Editor U.S. Govt. Press 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Schubring ဂ္ Marie Schmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3113 Twig Lane Bowie, MD. Barbara Schubring / spouse 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 03/04/2006 Alexandria, VA. 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee 6512 NW Crain Hwy. Bowie, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Glioblas **Physician** oma year /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a nonsequence of) Examiner tany leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No ó Month 4 Pregnant at time of death 5 Other (specify) Records, P.O. the ģ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check onli one Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2X No ٩ 28c. Injury at Work? 27. Manner of Death 28a. Date of fnjury (Month, Day Year, 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 2 Accident death. 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

10

MAR 0 1 2008

31. Date filed (Month, Day, Year)

Paul B. Berez, M.D.

2. Registrar's Signature

1655 Crofton Blvd.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suite 101

Crofton, MD.

			For State Registrar	State of Ma	aryland		artment of			,	giene Reg. No.	006	5	1801	9
			Decedent's Name (First, Middle, Last)						2. Date of De	ath			3. Time of De	ath
	Physici		Loretta	R			Smal	ensl	c:	Februar	Day 2	8 200		4:15	A M
\$	/Medic Examir		4a. Facility Name (If not institution, give	street and number)			4b. City, Town			· Especial	_	County of D	-		
	LAGIIII		The Johns Hopk	ins Hos	pital		Baltin	MAGE	City	1	ı	vone			
	Funeral		Social Security Number	x 7. Age	(In yrs. las	t birthday)	tf Under 1 Yea	r If Unde	er 24 Hrs.	8. Date of Bir (Month, Da	th V Yearl	9.	Birthplac	e (State or Fo	oreign
	Director		212 44 0633	M 21X F	61	Yrs.	Months Day	s Hours	Will.	Nov 1	4, 19	944 M	lary		
	g ,		Usuat Residence of Decedent 10a, State 10b, County		10c. City, 1	rl .							100	Tarida Obst	lantes.
	aryla	<u></u>	10a. State 10b. County										100	I. Inside City L 1 ☐ Yes 23	
	8a-f	ctc	MD Howard		Ellic	cott (<u></u>
	vith th	Director	10e. Street and Number				10f. Zip Code					zen of Whal			
	ath v	Ta .	10309 Globe Drive			1.5	210					nited			
	er de Item	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?		13.	Was Decedent of f Yes, specify Cu	iban, Mexic	an, Puerto	Rican, etc.)	-	14. Race - A Black, W			
36	rs aft	by F	1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2€ N If Yes, Give Year or Dates:	10		1 ☐ Yes 2 🕵 N	o Specif	y:			Specify:	Whi	. + 0	
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "netural", or Items 23e or 28a-f ehow he Medical Examiner must be notified at	ed	15. Decedent's Edu		1	16a. Deced	tent's Usual Occ	upation			16b. Kir	nd of Busine			
15	n "n	Completed	(Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4or 5		(Give	kind of work don DO NOT use reti	e during mo	ost of work	ng				,	
2	T the	E	Elementary/Secondary (0-12)	4	*/	Off:	ice Mana	ger			Ma	ırket	Rese	earch	
b	othe	Be C	17. Father's Name (First, Middle, Last)					18. Mot	her's Name	(First, Middle,					
a	Alenta Alenta rked tlc e	ToE	Richard J. Reddy,	Jr.				Cat	herin	e Thelr	na Ha	ırtman	ì		
ary	and h		19a. Informant's Name/Relationship (T)	/pe, Print)		19b. Mailir	ng Address (Stre	et and Num	ber or Rura	I Route Numbe	er, City or	Town, Stat	e, Zip C	ode)	
Ž	and 2 alith 27 I		John W. Smolenski/	Husband		10309	9 Globe	Drive	Elli	.cott Ci	Lty,	MD 21	042		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23e or 28a-1 show appring yor other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ F	Computal from State	20b. Plac	e of Dispo	sition (Name of natory or other p	lace)		Date	20c. Lo	cation - City	or Town	n, State	
Ĕ	Page ment ant: It		4 □ Donation 5 □ Other (Specify)		St.	Stan	islaus C	em.	3-3-2	:006	Balt	imore	, MI)	
a	permit. Departr Importa		21. Signature of Funeral Service Licens	6.100	M0104	14 22	. Name and Add	ress of Fac	ility Har	rv H. V	Vitzk	æ's F	ami]	v FH I	nc.
<u> </u>	89759	U. 9	Jun (olh	>-CVIlly		4:	112 Old	Colum	bia P	ike Ell	icot	t Cit	V. M	Ď 2104	3
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused ne cause on each lir	the death. I	Do not ent	er the mode of d	ying, such a	s cardiac o	or respiratory a	rrest,		In	pproximate iterval Betwee	n
	Physician		Immediate Cause (Final disease or condition	Motos	tatic	m	elanon	10						nset and Dea day	
	/Medical		resulting in death)	Due to (or as	aconsequen	nce of):	700	w.c.						0,000	
	Examiner		Sequentially list conditions,	b. Mye	loph.	this	5						7	day	5_
	pi ji	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
	icate be executed physician and s the burial-transit	Cam	that initiated events resulting in death) Last	c. <u>Melo</u> Due to (or as	mon	ra	of ax	illa					4	mont	75
8760,	cian cian curial	E	•	Due to (or as a	a consequer	ice or).									
87	physi the l	dical	•	d											
9 X	ding se as	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy	v							1.1		
Вох	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months?	1 ☐ Live birth	2 Fetal de	eath 3	Ectopic pregnar Other (specify)	су			2	3d. Date of Month	Da	ay Yea	r
P.O.	that the de ed by the detached	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknown	tarre or deat	3	Ottler (specify)								
	that the	, Ph	Part II. Other significant conditions co	ntributing to death bu	ut not resultir	ng in the u	nderlying cause o	iven in Par	ıt.	23e. Did to	obacco u	se contribut	e to the	cause of deat	h?
ds,	uires sign	d by								10	res 2	⊈ No 3 □] Probab	ly 4 ∐Unki	nown
200	w requir been si should	lete								24a, Was	30	24b Ware	autone	y findings ava	Jahla
Records,	ne lav s has ge 2	Completed								autop		prior	to comp	letion of caus	e of
Vital	iician: The lav certificate has rector, page 2		25. Was case referred to medical					00.01	- 15 11	1 Yes	2 No	101	/es 2[□ No	
5	sicia cert irect	o Be	examiner?	Hospital:	at 2 🗆 EB	VOutpatien		thor		(Check only o		G0:1		-	
ō	Phys rr this sral di	-	27. Manner of Death	28a. Date of Injur	y 28	Bb. Time of	28c. In	ury at		me 5 Residence 128d. Describe 1			рөсігу)		_
Division of	ding l	ioi ioi	1 X Natural 5 ☐ Pending investigation	(Month, Day	(Year)	tnjury		ork? ⊒Yes 2[□No						
Vis	or Attendate after death Director: A	ifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju	ry - At home	e, farm, str	eet, factory, offic	9		28f. Location (5		d Number or	r Rural R	loute Number	
Ö	el or A s after il Dire	Certification:	4 Romade	building, etc	s. (Specify)					City or Tov	vn, State)				
	To the Hospitel or Attending Physicien: The within 24 burs after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of	of my knowle	dge, death	occurred at the	time, date a	and place,	and due to the	cause(s)	and manner	r as state	ed.	
	the H in 24 ine Fi	Medical	one)	ner: On the basis of and manner sta	ted.										
	To t To t	Σ	29b. Signature and title of certifier		~		29c. Lice	nse number	,		29d. Date	signed (M	onth, Da	y, Year)	
			Jane Schill	Medi	cal D	octor	< Res	5-00	00	7	ebuc	ru.2	8,	2006	i .
5	a		30. Name and address of person who co	ompleted cause of de	eath (Item 23	За) (Туре.	Print)							2128	7
			Jane Schell, T	ne Johns	+604	cins t	bspital,	6001	Voryh	Wolfe S	Yeet	Balt	more	2, Mow	plan
	Sta		31. Date filed (Month, Day, Year)	32. Redistra	ır's Signatur	e 4	1							,	1
DH	Registr	-	MAR 0 2 2	me Johns 32. Redstra 2006	Wes ,	J. 19	03160								

	•	For State Registrar	State of M	larylan	id / Depa <i>Cei</i>	artme <i>rtifica</i>	ent of H ate of L	ealth a D <i>eath</i>	and M	ental Hy	giene Reg. No		6	08020
4 7 19		1. Decedent's Name (First, Middle, Last)								2. Date of D			Year	3. Time of Death
Physicia /Medica		WILSON	C	SA	GUB!	91V	Sa			FEBRU		26	2006	10:45 A M
Examine	er	4a. Facility Name (If not institution, give				4b. Cit	y, Town, or				40		of Death	4604
		SHADYGROVE ADI	VENTICE TA	HOSPI	TAL last birthday)	If Und	ler 1 Year	K VIL		8. Date of Bi	dh	MON		1604
Funeral Director	1		M 2□F	65	Yrs.	Month		Hours	Min.	Jan. 2	ay, Yea <i>r,</i>			place (State or Foreign ntry) ippines
p. ,		Usual Residence of Decedent								Jan. 2	J, 1	771		
ehov	2	10a. State 10b. County		Tuc. Cit	y, Town or Lo	cation							1	10d. Inside City Limits 1 ☐ Yes 2X No
the N	Director	MD Montgome	ery				hersb	urg			10a Ci	tizon of V	What Cou	
3a or	٥	17820 Chorlee Co	urt			101.2	.ip 0000	20	877				Stat	,
hours after death with the Maryland hours after death with the Maryland tural; or items 23s or 28s-1 show all Exert are must be notified at	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.	.S. 13.	Was Dec	edent of Hi	spanic Orig	gin? (Spec	cify Yes or Na Rican, etc.)		14. Rac	e - Americ	can Indian,
or its	y Fu	1 Never Married 2 Married	1 ∏Yes 2 📉 If Yes, Give				2⊠ No	Specify:		nican, etc.)		Specify	ck, White,	
fural :	ed by	3 Widowed 4 Divorced 15. Decedent's Edu	Year or Dates:		16a. Dece	dent's He	rual Occupa	tion			165 8		A	sian
LING Z1Z13- be filed within 72 tal Hygiene. d other then "nat event, the Medic	Completed	(Specify only highest grade		E.\	(Give	kind of v	vork done d use retired)	urina most	t of workin	g	100. F	ding of Bu	usiness/In	dustry
Maritime of the	E	Lienientary/Secondary (5°12)	4	3+)	Te	each	er				E	duca	tion	
	Be	17. Father's Name (First, Middle, Last)								(First, Middle		n Sumam	10)	
should be nd Mental marked o	၉	Vicente Saguban	an Oriati		105 14-75-					a Calu			A	
Man and Ith an	1	19a. Informant's Name/Relationship (Ty) Beatriz Saguban /				_	· ·			Route Numb	. ,			,
baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or paher traumatic angre.	1	20a. Method of Disposition			lace of Dispo	sition (N	ame of	1		ate				own, State
Page Title To The Title		1 ☐ Burial 2 【XCremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Met	emetery, crer cropoli Crema	ltan			March 2006		Δ1۵	vand	rio	Virginia
Baltimore, bermit. Pages 1 ar Department of Hea mportant: If them any injury or phie	Ī	21. Signature of Funeral Service License	90	,	22	. Name	y and Addres			ol Fun	eral	Hom	e, 10) East
D SQESS	4	(uetis E.	Day		De	eer]	Park I	rive	, Gai	ithers	ourg	, MD	2087	77
Physician		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that cause te cause on each l	ine.	n. Do not ent			, such as	cardiac or	respiratory a	rrest,			Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as		uence of):		·			-				
	e.	Sequentially list conditions, is any, leading to immediate	END ST		REA	AL	DIS	MSE						
d d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Ding	c-Files	М	Ess	armo f							
B exection and an arrial-tr		resulting in death) Last	Due to (or as		uence of):	to total	1.1.15.15.							
cate be executed physician and the burial-transit	dicai													
at the death certificate be executed to the attending physician and stached for use as the burial-transit	/Mec	IF FEMALE:	3c. If yes, outcome	of pregna							1		1	
Box leath cer attendir	by Physician/Me	in the past 12 months?	1□Live birth 4□Pregnant a	2 Fetal	death 3	Ectopic Other (s	pregnancy specify)					23d. Dat Mor	e of deliventh	ery Day Year
S of the second	nysi	1 Tes 2 No 9 Unknown	9□ Unknown				-,,/							
- 요 ㅎ	2	Part II. Other significant conditions con	tributing to death b	out not resu	ulting in the ur	nderlying	cause give	n in Part I.		23e. Did	obacco	use contr	ribute to th	ne cause of death?
							· · · · ·			1 🗆	Yes 2	□ No	3 Prob	ably 4 B Unknown
he law requires the law requirements.	Completed									24a. Was	psy		prior to col	psy findings available impletion of cause of
■ page										1 ☐ Yes	ormed? 2 🗷 No		death?	2 No
	o Re	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:		50/0		0.4			Check only				
9 Phys er this eral di	- t-	27. Manner of Death	28a. Date of Inju		ER/Outpatien 28b. Time of		28c. Injury Work	4 🔲 14UI		e 5 🗆 Resi 8d. Describe				γ)
ath.	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(MOIIII, Da	y rear)	Injury	М		es 2□N	No					
l or Attending after death. Director: After by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inj building, et	jury - At ho	ome, farm, stre	et, facto	ory, office		28	8f. Location (City or To			er or Rura	I Route Number.
		200 Contillor	leiner Tout	-4 :										
24 ho Fun etely f	Medical	29a. Certifier 1 → Certifying Phys (Check only one) 2 → Medical Examin	ician: To the best ier: On the basis of and manner st	if examinat	wiedge, death tion and/or inv	occurre restigatio	d at the time on, in my op	e, date and inion, deati	d place, ar th occurred	nd due to the d at the time,	cause(s date and) and ma d place, a	nner as si and due to	tated. the cause(s)
ro th within ro th comple	Z E	29b. Signature and title of certifier				25	9c. License	number			29d. Da	te signed	(Month,	Day, Year)
[0]		huerth an	thing	M.	0		000 9	5115	8		FEBR	ZUAR	4 26	5,2006
()		30. Name and address of person who co	mpleted cause of c	leath (Item	23a) (Type,	Print)								
15.0		VATTI . T. ANTHONY	19500		HR ANTIS	on	#3	al	enna	MOTON	N	MAI	RYLA	mo.
State Registra	-	31. Date filed (Month, Day, Year) MAR 0 1 20	32. Tegistr	ars Signal	7	ark								

			For State Registrar	State	of Maryla	nd / Depa <i>Cei</i>	artment of H tificate of	lealth a Death	and Mental		Ppe () 6		080	21
	Dhuniai		1. Decedent's Name (First, Middle	Last)					2. Date Mont	of Death	Day \	/ear	3. Time of	Death
П	Physici /Medio		Mary	Donahu	e Sh	ea			Febr		26 , 20		4:30	A. M
	Examir		4a. Facility Name (If not institution,	give street and no	ımber)		4b. City, Town, o	r Location	of Death		4c. County of	Death		
		:	Sunrise House				Rockvi	11e			Montg	omei	-у	
	Funeral		5. Social Security Number	6. Sex 1 □ M 2 🛣 F	7. Age (In yrs	s. last birthday)	If Under 1 Year Months Days	If Under Hours		of Birth h, Day, Y	ear)	9. Birthp	lace (State o	or Foreign
	Director		505-03-2529	1 M 2kg/F	90	0 Yrs.			Aug.		1915		raska	
	p v		Usual Residence of Decedent 10a. State 10b. County		100.0	City, Town or Lo	cation					T4	0d. Inside C	ity Limits
	sho	5			100.0							- 1.		2 No
	Ne N 28a-f	Director	Maryland Montgo	omery		Rockvi				- 40	077			
	with t		10e. Street and Number				10f. Zip Code			100	. Citizen of Wh	nat Cour	itry?	
	s 23	Funeral	8 Baltimore Roa			11.0	20850		i-i-2 (0if . V	au Ma	USA 14. Race	Amaria	an Indian	
	er de Item	nu	11. Marital Status 1 □ Never Married 2 □ Marrie	Armed F		U.S. 13. V	was Decedent of F f Yes, specify Cub	an, Mexicar	igin? (Specify Yes n, Puerto Rican, et	or No- :.)		White,		
36	rs aff	by F	3 ⊠ Widowed 4 □ Divorced	If Yes, G			1 ☐ Yes 2 🔀 No	Specify:			Specify:	T. T.		
Ş	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or Items 23a or 28a-f show ont, the Medical Evaninar must be redified at	ed	15. Decedent			16a, Deced	fent's Usual Occup	ation		16	b. Kind of Bus	Wh:		
15	in 72	Completed	(Specify only highes	t grade completed		(Give	kind of work done OO NOT use retire	during mos d)	t of working					
12	iene.	E	Elementary/Secondary (0-12)	College	(1-4or 5+)	Hou	sewife				Home			
ğ		Be C	17. Father's Name (First, Middle, L	ast)	·			18. Mothe	er's Name (First, M	iddle, Ma	iden Sumame,)		
au	id be id be ked o	To B	William	J.	Donah	nue			Mar	v	Agnes	N	loonan	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than 'naturel', or Items 23a or 28a-f show aumatic event, the Medical Examinet must be retified at	-	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	g Address (Street	and Numbe	er or Rural Route N					
Š	alith a		Brigit Sullivan	/ Daught	er	9 Mar	wood Cou	rt. Ro	ockville,	Mar	vland 2	2085	0	
altimore,	Hear Hear Hear Hear Cothe		20a. Method of Disposition	7		Place of Dispo	sition (Name of		Date		c. Location - C			
9	OSE SO		1 ☐ Burial 2 🖾 Cremation 4 ☐ Donation 5 ☐ Other (Sp				natory or other pla tan Crem	1	2 20 06	۸1	exandri	ia	Viroir	าว่อ
₫	artme ortar injur		21 Securiture of Funeral Service L) () (2-20-00 by DeVol F				V 11 611	iza
Ba	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any injury or other traumatic even.		> lucle	-CINX	melek				rk Dr., G				D. 208	377
	انست		23a. Part1. Enter the disease, or	complications that	caused the dea							5, 11	Approximat	:ө
ΑĒ			shock, or heart failure. List of Immediate Cause (Final	only one cause on	each line.		,			•			Interval Bet Onset and	
н	Physician /Medical		disease or condition resulting in death)	a. Demer								-		
	Examiner				orasa conse									
		e.	Sequentially list conditions, if any, leading to immediate		(or as a conse									
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
,	exector and and ial-tra	Еха	resulting in death) Last	C. Due to	(or as a conse	equence of):								
8760	ficate be executed physician and s the burial-transit	dicai		L _d										
89	ificati g phy as the	edic												
Box	death certifi e attending p id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		itcome of pregr						23d. Date	of delive	ery	
ň	death a atte d for	icla	in the past 12 months? 1 ☐ Yes 2 TNo	4□Preg	birth 2 ☐ Fel nant at time of]Ectopic pregnanc;] Other (s <i>pecify)</i> _	<u> </u>			Mont	n	Day ,	Year
0	at the de by the a tached	hys	9 Unknown	9□ Unki	nown									
o.	The law requires that the site has been signed by this age 2 should be detached.	by P	Part II. Other significant condition	ns contributing to	death but not re	sulting in the ur	nderlying cause giv	en in Part I	. 23ө.	Did toba	cco use contrib	ute to th	ne cause of c	leath?
p	quire in sig uld b	pg p	Atrial Fibrilla	tion, Co	ngestiv	e Heart	: Failure			1 🗌 Yes	2 🖾 No 3	☐ Prob	ably 4 □l	Jnknown
000	w requires been si should b	lete							24a.	Was an	24b. We	ere auto	psy findings	available
He	: The taw cate has b page 2 s	Completed								autopsy performe	d? de	ath?	impletion of c	ause of
		ပိ	25. Was case referred to medical					26 Place	of Death (Check	es 25	₫No 1L	Yes	2□ No	
>	ysicien: nis certifica director,	0	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	☐ ER/Outpatien	Ott		ursing Home 5		e 6 MOther	(Specifi	Assis	ted
Division of	ding Phy h. After this funeral c	F 1	27. Manner of Death	28a. Date	of Injury	28b. Time of	28c. Injur	y at			injury occurred		LIVII	i E
o	nding th. :: Afte	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investig.		nth, Day Year)	Injury	M 1 🗆	K? Yes 2 🔲	No					
S	ol or Attendi after death. I Director: A d in by the fu	ifice	3 Suicide 6 Could n	ned 200. Flat	e of Injury - At I	home, farm, stre	eet, factory, office				et and Number	or Rura	l Route Num	ber,
á	ipitel or A ours after ierel Direc filled in by	Certification;	4 _ Homicide	build	ling, etc. (Spec	eny)			City	r Town, S	State)			
	spite		29a. Certifier 1∑ Certifying	Physicien: To th	e best of my kr	nowledge, death	occurred at the tir	ne, date an	id place, and due to	the cau	se(s) and manr	ner as si	ated.	
	e Ho 1 24 } 1e Fu	edical	(Check only 2 Medical E	xeminer: On the and mai	pasis of examin nner stated.	nation and/or inv	estigation, in my o	pinion, dea	ith occurred at the	ime, date	and place, an	d due to	the cause(s)
	To the Hospitel or Attending Physicien: within 24 hours after deals. To the Funerel Director: After this certific completely filled in by the funeral director,	Me	29b. Signature and the of certifier	1			29c. Licens	e number	-	29d	. Date signed (Month,	Day, Year)	
-	20) lace	Cal	u	-	י ת	0367		Tr.	bruary	27	2006	
			30. Name and address of person v	vho completed cau	se of death (Ite	em 23a) (Type.		000/		F	-DIUALY	419	2000	
			Joel Kalman, M.			, , , , ,	· ·	11e.	Marvland	208	50			
	Sta	te	31. Date filed (Month, Day, Year)	36	Registrar's Sign	nature	A ROCKVI							
	Registr		MAR 01	2006	and A	5 /								

			1 - For State Registrar	State of M	1arylan		artmen <i>tificat</i>			and M		Reg. No.	06	08022
	Physici	an	Decedent's Name (First, Middle, MARILYNN V.	Last) SMITH							2. Date of De Month	Day	Yeer 8, 2006	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, Saint Josep	•		ter	4b. City,	Town, or	Location o	of Death			ounty of Death Ball	cimore
	Funeral Director		204-03-2250	3. Sex 7. A 1 ☐ M 2 Ă F	ige (In yrs. 83	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir Month Da 1/28/I	th y <i>Year)</i> 923	9. Birth Con Per	nplace (State or Foreign Intry) Insylvania
	Maryland a-f ahow	tor	10a. State 10b. County PA York		10c. Cit	y, Town or Lo New	cation Park							10d. Inside City Limits 1 ☐ Yes 2 No
	n with the	al Direc	10e. Street and Number 1063 Main Stre	et			10f. Zip	Code 1735	2			_	on of What Co JSA	untry?
920	s 1 and 2 should be filed within 72 hours after death with the Maryland feath and Manial Hygiene. Itam 27 Is marked other than "natural", or Itema 23s or 28s-f show other traumatic avant. In a Madical Examination must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceden Armed Forces d 1 Tes 2 If Yes, Give Year or Dates	? ZNA		Was Deced f Yes, spec	-	spanic Ori n, Mexicar Specify:	gin? (Spe n, Puerto I	city Yes or No Rican, etc.)		1. Race - Amer Black, White Specify: V	
Maryland 21215-0036	d within 72 ho giene. Ir then "natur	Completed by	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		r 5+)		dent's Usua kind of wo DO NOT us emake	rk done d se retired	ition Juring mos)	t of workii	ng		of Business/I wn Home	•
/land	should be filed ind Mental Hygis marked other urnatic avant, it	To Be (17. Father's Name (First, Middle, L David Maurice						18. Mothe		(First, Middle) a Acker		'umame)	
	1 and 2 sho Health and I Iam 27 Is my		19a. Informant's Name/Relationshi Karen L. Roupe/I			952	Mt.	Oliv					Town, State, Z Grove,	
Baltimore,	Pages 1 and nent of Health int: If item 27 ury or other to		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Sp.		C	Place of Dispo emetery, cren Vince	natory or o	ther plac			2006		ation-City or Ver, PA	
Balti	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service	Lovelle	der		Name ar arkin				e, Inc.	, Dei	lta, PA	17314
)	Physician /Medical Examiner		23a. Part 1. Enter the disease, or of shock, or heart lature. List of immediate Cause (Final disease or condition resulting in death)	a. ACUTE Due to (or a	MYO	CARDI					r respiratory a	rrest,		Approximate Interval Between Onset and Death
8760,	ate be executed thysicien and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	CDue to (or a		· ·								
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	Ideath 3□	Ectopic pa					23	d. Date of deli Month	very Day Year
rds, P.	quires that n signed b	δ	Part II. Other significant condition	as contributing to death	but not res	ulting in the u	nderlying o	ause give	n in Part I	•	23e. Did t			the cause of death?
Il Records,	ding Physician: The law requin h. Atter this certificate has been si funerat director, page 2 should	Completed									24a. Was auto perio 1 🗆 Yes		24b. Were au prior to death? 1 🗆 Yes	topsy findings available completion of cause of
Vital	Physician: this certificatal director,	To Be	25. Was case relerred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital:	tient 2 🖺	ER/Outpatier	at 3□ DC	Othe	ar		(Check only one 5 ☐ Resi		☐Other (Spec	eify)
	Attanding Phy r death. actor: After thi by the funeral o		27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D		28b. Time of Injury		28c. Injury Work		2	28d. Describe			4
Division	al or Attandi sefter death. I Diractor: A d in by the fu	Certification:	3 Suicide 6 Could no 4 Homicide determin	200. Place of I	njury - At ho etc. (Specif	ome, farm, str	eet, lactor	y, office			28f. Location (City or To		Number or Ru	ral Route Number,
	To the Hospital or Attend within 24 hours efter deati To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) Certifying Certifying Certifying	Physician: To the bes xaminer: On the basis and manner:	of examina	wledge, death	occurred vestigation	at the tim	ie, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) a date and p	nd manner as place, and due	stated. to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title ol certifier		2	-	290	c. License	number				signed (Month	
			1 Olon	220	ec			D 39	1263			0	3-08-	96
	10		30. Name and address of person w	no completed cause of	death (Iten	n 23a) (Type,	Print)	etari ma	a seeds from a					
	Sta Registi		31. Date filed (Month, Day, Year)		trar's Signa	iture	RIVE	- TO l	14081	-MAR	YLAND	2121	24	···

			For State Registrar		epartment of Health and N Certificate of Death	fental Hygie Reg.	C. C. C.	08023
	Physici		1. Decedent's Name (First, Middle, La CHARLES LEWIS			2. Date of Death Month MARCH 1	Day 2006	3. Time of Death 4:40 A M
\	/Medic Examin Funeral Director		230-44-0034	URSING & REHAB.	4b. City, Town, or Location of Death WALKERSVILLE If Under 1 Year	8. Date of Birth (Month, Day Ye FEB 27	FREDERIC 9. Birthp Court 1933	lace (State or Foreign
	ow at		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		1	0d. Inside City Limits
	e Many Se-f sh	Director	MD MONTG	OMERY BOY	DS			1 ☐ Yes 2 No
	with th		10e. Street and Number 21031 SUGAR RII	OGE TERRACE	10f. Zip Code 20841	10g.	Citizen of What Cour	ntry?
036	72 hours after death with the Maryland neturel', or Items 23a or 28e-f show illed Examiner mat be rediffed at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ Nol 957 — If Yes, Give Year or Dates: 1959	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: WH	etc.
21215-0036	within ane. then *	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) IENTIST	ring	HYSIOLOG	•
nd	Hygent,	Be	17. Father's Name (First, Middle, Last,			e (First, Middle, Mai		
Maryland	Mer Mer arke	일	ERNEST ERVIN TO		NELL Mailing Address (Street and Number or Rui	BURLESO		(Code)
	2 4 8 8 9		MARJORIE TURBY		1031 SUGAR RIDGE			
altimore,	8 = 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the control	Removal from State BOYDS	Disposition (Name of commands), crematory or other place) PRESBYT. CHURCH	706 B	OYDS, MD	
Balt	permit. Page Department of Importent: If eny injury or 2002e.		21. Signature of Funeral Servin Lice) 1	22. Name and Address of Facility HILTON FUNERAL		O. BOX 80	E, MD
Total San	Pnysician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	ot enter the mode of dying, such as cardiac nic Obstructive Lung I			proximate Interval Between Onset and Death
68760,	ficate be executed g physician and ts the burial-transit	edical Examiner	Sequentially list conditions, any, baong to immable cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c				
O. Box	death certi e attending ed for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ery Day Year
٥.	es that igned b be deta	by Pr	Part II. Other significant conditions of	contributing to death but not resulting in	the underlying cause given in Part I.		co use contribute to the	
of Vital Records,	The law requir ate has been s page 2 should	Completed				24a. Was an autopsy performer	24b. Were auto prior to cor death?	psy findings available mpletion of cause of 2 No
VIII	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outs	Other	h (Check only one)	e 6 □Other (Specify	w)
	ding h. After fune	 	27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year) 28b. Ti		28d. Describe how i		<i>''</i>
Division	el or Attendi s after death. si Director: A ed in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fam building, etc. (Specify)	m, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rura (tate)	l Route Number,
	To the Hospitel or Attu within 24 hours after de To the Funerel Direct completely filled in by the	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example	nysician: To the best of my knowledge, niner: On the basis of examination and and manner stated.	death occurred at the time, date and place, /or investigation, in my opinion, death occur	and due to the caus red at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
	To the within To the comp	Me	29b. Signature and title of centifier	H	29c. License number	29d.	Date signed (Month,	Day, Year)
	1		30. Name and address of person who	completed cause of death (Item 23a) (7	D21944	M	excen 3, 2	.006
	6		James S. GRIDE	1/100	4	LICK, MI	21702	
:	Sta Regist		31. Date filed (Month, Day, Year) MAR 0 3	32. Projistrar's Signature	Acres 1			

A Facility have a prior installation gos steel and number of Sacched Reacht flos petical and the sacched flos petical and the sacche	Physic			lame (First, Midd Elwood		an							2. Date of De Month 02	eath Day	16	Y 9 %	3. Time of D
21.8-40-31.36 Texas Content Texas Content			4a. Facility Nam	ne (If not institutio	n, give street	and number,)		4b. City,	Town, or	Location of Land	of Death	02	4c. (County	of Death any	
Total State Total County PA Sometis et al. 100. County PA 100. Count			218-40	-3136									(Month, Da	ay, Year)		9. Birthp Coun	
Sementary/Secondary (0.12) College (1-4or 5+) Machine Operators interest Medicine Activiting	a-f show	ctor	10a. State	10b. County					ocation							1	
BlammarinySecondary (0.12) College (1-4or 5+) Machine Operators Manuage (1-1or 5+) Machine Operators Manuage (1-1or 5+) Machine Operators Manuage (1-1or 5+) Machine Operators Machine Operators Manuage (1-1or 5+) Machine Operators Manuage Machine Operators Manuage Machine Operators Manuage Machine Operators Machine Operators Manuage Machine Operators Machine Operators Machine Operators Manuage Machine Operators Machine Operators Machine Operators Manuage Machine Operators	3a or 28 at be no	al Dire			lill Rd											Vhat Coun	itry?
BlammarinySecondary (0.12) College (1-4or 5+) Machine Operators Manuage (1-1or 5+) Machine Operators Manuage (1-1or 5+) Machine Operators Manuage (1-1or 5+) Machine Operators Machine Operators Manuage (1-1or 5+) Machine Operators Manuage Machine Operators Manuage Machine Operators Manuage Machine Operators Machine Operators Manuage Machine Operators Machine Operators Machine Operators Manuage Machine Operators Machine Operators Machine Operators Manuage Machine Operators	rel', or iteme 2 Examiner mu	þ	1 Never N	Married 20 Mar	ned 1 [med Forces' ∐Yes 2 🔀 Yes, Give	? No	l.S. 13.				gin? (Spi i, Puerto	ecify Yes or No Rican, etc.)		Black	k, White,	etc.
18. Moher's Name (First, Model), Marken Sumanne) 18.	iene. Then "natu the Mudical	ompletec		Specify only highe Secondary (0-12)	st grade comp	pleted)	5+)	(Give	kind of wo DO NOT u	ork done d ise retired	during mosi)	t of work	ing				
23a. Plant. Either the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, medical causes of condition and the disease of conditions and the disease of conditions are setting in death). 25 Emphysema - Chronic obstructive Lung disease of conditions are setting in death). 26 Emphysema - Chronic obstructive Lung disease of conditions are setting in death). 27 Emphysema - Chronic obstructive Lung disease. 28 Emphysema - Chronic obstructive Lung disease. 29 Emphysema - Chro	mental ryg arked other atic event,	ag a		me (First, Middle,				- Macri	rne v	pera	18. Mothe	er's Name	(First, Middle I A. Br	, Maiden S	Sumame	<u>ссии</u>	cng
23a. Plate. Either the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between the cause of cachiling in death). 25	27 is m r traum					•								-			
23a. Plint. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mode of cause on each line. 23a. Plint. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mode of dying, such as cardiac or respiratory arrest, mode of dying, such as cardiac or respiratory arrest, mode of dying, such as cardiac or respiratory arrest, mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of death and the mode of dea	nent of Hez int: If item iry or othe		1 🔀 Burial	2 Cremation		al from State	, c	Place of Disponentery, crea	osition (Nar matory or o	me of other place	ī	ľ	Date	20c. Loc	cation - (City or To	wn, State
23a. Platt. Enter the disease. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause one each line. It immediate Cause (Final shock, or heart failure). List only one cause one each line. It immediate Cause (Final shock) or heart failure). List only one cause one each line. Due to (or as a consequence of): Sequentially list conditions or immediate cause. Enter Underlying cause. Enter Underlying cause. Enter Underlying cause or insult that in the past 12 months? In the past 12 months In the past 12 months In the past 12 months In the past 12 months? In the past 12 months In the past 12	Separtm mporte iny inju		21. Signature o	f Funeral Service	Licensee		100,				s of Facilit		2000	- 19	LOLITION	,	•
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1			snock, or	neart failure. List	only one cau	ise on each i	ine.	h. Do not en	HULVE ter the mod	y H. de of dying	Zeig g, such as	Let cardiac c	or respiratory a		ie, i	Hyndri	Approximate Interval Between
25. Was case referred to medical examiner? Solution Part P	ysician Medical aminer	Examin	snock, or tmmediate Cau disease or con- resulting in dea Sequentially lis if any, leading t cause. Enter U Cause (Diseast that initiated ev.	near failure. List isse (Final dition of the conditions, of immediate inderlying of injury ents	a b. E	End Due to (or as Due to (or as	Staces a consequence of the staces of the st	th. Do not en age re vence of): uence of): the heart of the control of the cont	Have ter the mod	y H. de of dying -ato	Zeig g. such as ry fo obst	let cardiac c ailu	r respiratory a	rrest,			Approximate Interval Betwe Onset and De
25. Was case referred to medical examiner? The street of the street o	ysician and sedical and purial-transit	Examin	snock, or tmmediate Cau disease or con- resulting in dea Sequentially lis if any, leading t cause. Enter U Cause (Disease that initiated ev- resulting in dea	near failure. List isse (Final dition of the conditions, of immediate inderlying of injury ents	a b. E	End Due to (or as Due to (or as	Stac s a consect y se a consect stive	th. Do not en age re vence of): uence of): the heart of the control of the cont	Have ter the mod	y H. de of dying -ato	Zeig g. such as ry fo obst	let cardiac c	r respiratory a	rrest,			Approximate Interval Betwe Onset and De
25. Was case referred to medical examiner? Second Part Part	ittending physician and busing a single consequence of the purial transit consequence of the consequence of	Examin	snock, or the mediate Cau disease or con-resulting in dea Sequentially list if any, leading to cause. Enter U Cause (Disease that initiated evresulting in dea IF FEMALE: 23b. Was decein the past 1 \$\square\$ Yes	neart railure. List isse (Final diftion th) t conditions, or immediate inderlying a or injury ents th) Last	a	Due to (or as Du	Staces a consequence of pregna 2 Fetal	th. Do not en	Hurve ter the mod Spic Chror Chror	y H. de of dying a to nic fai	Zeig g. such as ry fo obst	let cardiac c	r respiratory a	dis	SCA S	e of delive	Approximate Interval Betwee Onset and De Oyce Cs
25. Was case referred to medical examiner? Yes 25 No	And the attending physician and control of the purial-transit cont	by Physician/Medical Examin	snock, or tramediate Cau disease or conresulting in dea Sequentially lis if any, leading to cause. Enter U Cause (Disease that initiated evresulting in dea IF FEMALE: 23b. Was decein the past 1 □ Yes 9 □ Unknot	dent pregnant 112 months? 2 □ No	a	End Due to (or as	s a consequence of pregnatutime of definitions.	Ancy of death 3 [leath 5 [Hurve ter the mod Spir Chror Chror	de of dying a to	Zeigg, such as ry for obsti	cardiac cailu	respiratory a respiratory a respiratory a	23 dis	SCA S 3d. Date Mon	e of delive	Approximate Interval Betwee Onset and De O Y Ca CS
The Natural 1	A series to the attending physician and in a series and in a series as the burial-transit in a series as the ser	by Physician/Medical Examin	snock, or tramediate Cau disease or conresulting in dea Sequentially lis if any, leading to cause. Enter U Cause (Disease that initiated evresulting in dea IF FEMALE: 23b. Was decein the past 1 □ Yes 9 □ Unknot	dent pregnant 112 months? 2 □ No	a	End Due to (or as	s a consequence of pregnatutime of definitions.	Ancy of death 3 [leath 5 [Hurve ter the mod Spir Chror Chror	de of dying a to	Zeigg, such as ry for obsti	cardiac cailu	23e. Did 1	2: Tobacco us Yes 2 an psy an	3d. Date Mon	e of deliventh ibute to th Troba	Approximate Interval Between Conset and De Oyce Con
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and the of certifier (Check only one) 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)	A series to the attending physician and in a series and in a series as the burial-transit in a series as the ser	Be Completed by Physician/Medical Examin	snock, or tramediate Cau disease or con-resulting in dea Sequentially lis if any, leading to cause. Enter U Cause, Olisease that initiated evresulting in dea IF FEMALE: 23b. Was decein the past 1 Tyes 9 Tunknot Part II. Other sie examiner?	neart railure. List isse (Final dition ith) t conditions, o immediate inderlying e or injury ents ith) Last dent pregnant to modificant conditions own gnificant conditions deferred to medical	a	Due to (or as Du	s a consequence of pregna 2 Fetal It time of default not rest	Annual death 3 [leath 5 [Hurve ter the mod Spir Chror Chror Chror Chror Chror Inderlying c	de of dying a do nic fair regnancy pecify)	2 eigg, such as	cardiac of Death	23e. Did to 1 Kg autoperformer to 1 Kg autop	23 23 25 26 26 27 27 27 27 27 27 27 27 27 27 27 27 27	3d. Date Mon	e of deliventh ibute to th 3 □ Probi Vere autor eath? □ Yes	Approximate Interval Between Conset and De Oyce Con
and manner stated. 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)	After this certificate has been signed by the attending physician and the property of the prop	To Be Completed by Physician/Medical Examin	snock, or tramediate Cau disease or conresulting in dea Sequentially lis if any, leading to cause. Enter U Cause, Olisease that initiated evresulting in dea IF FEMALE: 23b. Was decein the past 1 — Yes 9 — Unknot Part II. Other signature of the past 1 — Yes 2. Was case reasonine?? 1 — Yes 2. Was case of examiner? 2. Manner of C 1 Manner	dent pregnant to medica to	a	Due to (or as Du	s a consequence of pregna 2 Fetal It time of disput not rest	ancy of death 3 [leath 5 [leat	Ectopic production of the state	regnancy sectify)	2 eigg, such as ry for obstitute obstitute 26. Place 17. 4 Nu at at 27. 4 Nu at at The such as The	of Death	23e. Did to the substitute of	23 25 26 27 27 27 28 28 29 29 20 20 20 20 20 20 20 20	3d. Date Mon 3d. Date Mon 24b. W production of the occurre	e of deliventh a Probate autoprior to cone eath? The search of the sea	Approximate Interval Betwee Onset and De Oy Ca C S
	After this certificate has been signed by the attending physician and the property of the prop	Certification: To Be Completed by Physician/Medical Examin	snock, or tramediate Cau disease or conresulting in dea Sequentially lis if any, leading to cause. Enter U cause. Enter U cause (Disease that initiated evresulting in dea Sequentially list of the past of the pa	dent pregnant to 12 months? 2 No	a	Due to (or as Du	s a consequence of pregna 2 Fetal It time of de court not rest	ancy of death 3 [leath 5 [leat	Ectopic production of the second of the seco	regnancy becity) Da Dthe Bec. Injury Work y, office	2 et g g, such as obst obst con in Part I. 26. Place or: 4 Nu at r date and	of Death	23e. Did to 1 Yes 24a. Was autopended to 1 Yes 25d. Describe 28d. Describe	obacco us Yes 2 an psy ormed? 2 (XNo one) dence 6 how injury	3d. Date Mon Se control No 24b. W pin did Se control 1 l	e of deliventh a probate autoprior to cone eath? or or Rural	Approximate Interval Betwee Onset and De Oy Ca Conset and De Oy Ca Conset and De Oy Ca Conset and De Cause of dea ably 4 Unit of Desy findings avanpletion of cause of Desy findings avanpletion of Cause Oy Desy findings avanable Oy Desy findings avanable Oy Desy findings avanable Oy Desy findings a

DHMH 17 Rev 1/2001

ORIGINAL

			1 - State Registrar		yland / Dep <i>Ce</i>	artment of F	lealth and I <i>Death</i>		giene 🕦 🕦	6 08025
	Physic	ian	Decedent's Name (First, Middle, L	,				2. Date of De Month	Day	3. Time of Death
	/Medi		· · · · · · · · · · · · · · · · · · ·	RT DENNIS	THOMAS	Jr.		Feb	25, 200	
	Examir	ner	4a. Facility Name (If not institution, g.			4b. City, Town, o	r Location of Deatl	1	4c. County of	Death
			19438 Zinnia			German			Montgo	
	Funeral Director		216-30-3832	1⊠ M 2 F	In yrs. last birthday, Yrs.	Months Days	If Under 24 Hrs. Hours Min.	(Month, Da		9. Birthplace (Siete or Foreign Country) Maryland
	and w		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or L	ocation				10d. Inside City Limits
	Ba-f eh	Funeral Director	MD Montgo	omery	Germa				·	1 ∑ Yes 2 ☐ No
	Mith t	늄	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
	a 23	era i	19438 Zinnia	12. Was Decedent Eve		208			U.S.A	
2-0036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other then "natural", or itema 23a or 28a-1 show imatic event. In Madical Exeminations the notilined at	à	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ X Divorced	Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		American Indian, White, etc. Black
0	72 ho	ted	15. Decedent's 8 (Specify only highest g	ducation	16a. Dece	dent's Usual Occup	ation		16b. Kind of Busi	ness/industry
Maryland 2121	within 7 ene. then "r	Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	0	xing	Montgo	mery County
D D	filed Hygid other	S	17. Father's Name (First, Middle, Las	t)	Bul.	lding Se		ne (First, Middle,	Maiden Sumame)	Schools
<u>la</u> n	And be dental rked o	To Be	Robert G.	Thomas					. Owens	
ary	shou and N man	Γ.	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street a				
_	and 2 salth n 27 i		Mildred Arthu	ır- Sister	864	44 Fount	ain Val	ley Dr	Mont V	ill,MD20886
ore	of He		20a. Method of Disposition 1 Burial 2 □ Cremation 3		20b. Place of Dispo cemetery, cre-	osition (Name of matory or other plac	θ)	Date	20c. Location - Ci	ty or Town, State
Ē	tinent funt:		4 □ Donation 5 □ Other (Spec	fy)	Warren	Church				son, MD
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 ie marked eny injury.gpother traumatic events.		21. Signature of Funeral Service Lice	Insee	//	2. Name and Addres $246\mathrm{N}_{ullet}\mathrm{W}$				1 Home, PA 1e, MD20850
			23a. Part1, Enter the disease, or cor shock, or heart failure. List only	oplications that caused the						Approximate
	Physician		Immediate Cause (Final disease or condition		CELL LUI	NG CANCE	R			Interval Between Onset and Death 5 Weeks
	/Medical Examiner		resulting in death)	Due to (or as a c	onsequence of):					J WEEKS
ı	LXammer	L	Sequentially list conditions,	b						
	ted	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	опѕециенсе от).					
<u>,</u>	ficate be executed physicien and is the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a c	onsequence of):					
98/60	ite be ysicie	edical		d						
_		Jedi	IE ECHALC:							
O. Box	s that the death certifi ned by the attending e detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1 Live birth 2 [4 Pregnant at tim 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	-
1	that the	y Ph	Part II. Other significant conditions	contributing to death but n	ot resulting in the u	nderlying cause give	in in Part I.	23e. Did to	bacco use contribu	ute to the cause of death?
ecords,	w requires to been signer should be a	eted by								☐ Probably 4 ☐ Unknown
ဝင္ပ	E 25 CF	plet					_	24a. Was a		re autopsy findings available
	Tage 1	Compl						perfor	med? dea	r to completion of cause of th? Yes 2 XNo
VItal	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?				26. Place of Deal	h (Check only or	пеј	
=	a si ii	P	1 Yes 2 No		2 ER/Outpatien		4 Nuising no		ence 6 Other	(Specify)
5	iding Ph th. After th funeral	ertification:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Ye	ear) 28b. Time of Injury	Work	at ? ′es 2 □ No	28d. Describe h	ow injury occurred	
JIVISION	Atten r deal ector: by the	fica	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Injury	- At home, farm, str		63 2 110	28f. Location /S	treet and Number	or Rural Route Number.
5	tal or	OL	4 Homicide	building, etc. (3	Specify)	,,		City or Tow	n, State)	
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	edicai	29a. Certifier (Check only one) 1 XCertifying Pl	nysician: To the best of miner: On the basis of exand manner stated	amination and/or inv	occurred at the tim vestigation, in my op	e, date and place, inion, death occur	and due to the cred at the time, of	ause(s) and manne date and place, and	er as stated. I due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	450	7	29c. License		2	29d. Date signed (A	, , ,
	(0		1 gens	7 - 30	48	D43	083		Feb.	28, 2006
	Ψ		30. Name and address of person who Dr. George Sc				ter Dr#	300 Ro	ckville	. MD 20850
	Sta		31. Date filed (Month, Day, Year)	Registrar's	Signature	طر کھی	Σ-π	200 1101	-11.47776	, 110 20000
	Registra	al	MAR 01 20	Ub Buch	JS Ages					

State of Maryland / Department of Health and Mental Hygiene 16 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year BARBARA JANE TURNER Feb 24 2006 8:42A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ ME 217-36-6176 Director 71 Yrs Nov. 26, 1934 Wash, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show treumatic event, the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 503 North Horners Lane 238 20850 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 ŏ 1 Yes 2 No Specify: Black Completed by 3 XWidowed 4 ☐ Divorced "naturel", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Montgomery Co. Elementary/Secondary (0-12) College (1-4or 5+) llth Cafeteria Worker Public Schools permit. Pages 1 and 2 should be fits
Department of Health and Mental Hy
important: if item 27 is marked othe
eny injuy, go pthar the control of the control 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown Cecelia E. Stevenson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norman Mullen- Brother PO Box 1231 Rockville, MD 20850 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Gate of Heaven 3/4/2006 Silver Spring, MD 21. Signature of Funeral Serves Licensee 22. Name and Address of Facility Snowden Funeral Home, P.A. 246 N. Washington St Rockville, MD20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Heart ailune **Physician** /Medical Due to (or as a consequence of): Examiner palmonal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): rombo pinto Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably ★ Unknown Completed + 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; Division 1 Natural 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ŏ To the Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) amalineil 20020415 nowoll 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0001 LUX LN DE HAPANDE 1 KAMALINGE 31. Date filed (Month, Day, Year) . Registrar's Signature 0 1 2006 Registrar

CAPBARA

22N2

0

artment of Health and Mental Hygiene. ortant: If Ilem 27 is marked other than "naturel", or items 23a or 28e-1 show ortant: If Ilem 27 is marked other than "naturel", or items 23a or 28e-1 show ortant: If Ilem 27 is marked other than "naturel", or items 23a or 28e-1 show ortant: If Ilem 27 is marked other than "naturel", or items 23a or 28e-1 show and Illumination and Illu	5. S. S. 2. Usu 10a. 10a. 11. 17. 19a. D. 20a	Ial Residence of Decedent State 10b. County MD QUEEN AND Street and Number 1706 BRIDGEPOINTE Marital Status 12 I Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educa (Specify only highest grade elementary/Secondary (0-12) 12 Father's Name (First, Middle, Last)	DRIVE 7. Age (In yrs. Ia 81 10c. City, NE C DRIVE 2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 2 No If Yes Give Year or Dates: ation completed) College (1-4or 5+) DRIVE	Ast birthday) Yrs. If Un Mont Town or Location HESTER 10f. 3. Was De If Yes, 1 Circle kind of Iffe. Do No	Zip Code 21619 Zip Code 21619 Zip Code 21619 ADMINI ADMINI	If Under 24 Hrs. Hours Min. panic Origin? (S, Mexican, Puert	8. Date of Birth SEPT 29	4c. County of Ac. County of QUEEN Yell'24 I	Dirthplace (State or Fore PENNSYLVANIA) 10d. Inside City Lin 1 Yes 2 X at Country? American Indian, White, etc.
trient of Health and Mental Hygiene. Tant: If Item 27 is marked other than "naturel", or Items 23a or 28e-f show a faut: or other traumatic event, If a MacTeal Examinat must be notified at a lighty or other traumatic event, If a MacTeal Examinat must be notified at a light or other traumatic event, If a MacTeal Examinat must be notified at a light or other traumatic event, If a MacTeal Examinat must be notified at a light of the	2 Usu 10a. 10a. 10a. 11a. 11a. 11a. 11a. 11a.	O2-12-9318 Ital Residence of Decedent Ital Resi	DRIVE 2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Mo If Yes, Give Year or Dates: ation completed) College (1-4or 5+) -0-	Town or Location HESTER 10f. 13. Was De If Yes, s 1 Ye 16a. Decedent's U (Give kind of life. Do No	Zip Code 21619 cedent of His specify Cuban, s 2 No Sual Occupet work done du T use retired) ADMINI	panic Origin? (S , Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	0g. Citizen of Wh USA 14. Race - Black, Specify:	at Country? American Indian, White, etc.
tment of Health and Mental Hygiene. tant: If Item 27 is marked other than "naturel", or items 23a o jury or other traumatic event, It's Madical Examinat must be jury or other traumatic event, It's Madical Examinat To Be Completed by Funeral D	10a. 10a. 10a. 11a. 11a. 11a. 11a. 11a.	Description of the informant's Name/Relationship (Type) No. Street and Number 1706 BRIDGEPOINTE Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educa (Specify only highest grade of the information of the in	DRIVE 2. Was Decedent Ever in U.S. Armed Forces? 1	HESTER 10f. 13. Was De If Yes, 3 1 Ye 16a. Decedent's U (Give kind of life. DO NO	21619 Incedent of Hisispecify Cuban, s 2 No Isual Occupet work done du Truse retired) ADMINI	panic Origin? (S , Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	USA 14. Race-Black, Specify:	1 □ Yes 2 XI at Country? American Indian, White, etc. WHITE
tment of Health and Mental Hygiene. tant: If Item 27 is marked other than "naturel", or items 23a o jury or other traumatic event, It's Madical Examinat must be jury or other traumatic event, It's Madical Examinat To Be Completed by Funeral D	17. 19a D	Arrital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educa (Specify only highest grade) 16. Decedent's Educa (Specify only highest grade) 17. Decedent's Educa (Specify only highest grade) 18. Testher's Name (First, Middle, Last) 19. WA'I HU 19. A. Informant's Name/Relationship (Type of the content of th	2. Was Decedent Ever in U.S Armed Forces? 1 □ Yes, 2 MNo If Yes, Give Year or Dates: ation completed) College (1-4or 5+) -0-	13. Was De If Yes, s 1 □ Ye 16a. Decedent's U (Give kind of life. DO NO	21619 Incedent of Hisispecify Cuban, s 2 No Isual Occupet work done du Truse retired) ADMINI	panic Origin? (S , Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	USA 14. Race-Black, Specify:	American Indian, White, etc. WHITE
tment of Health and Mental Hygiene. fant: If Item 27 is marked other than "naturel", or jury or other traumatic event, I're Mudical Exam To Be Completed by	17. 19a D	1 Never Married 2 Married 3 XWidowed 4 Divorced 15. Decedent's Educa (Specify only highest grade is lementary/Secondary (0-12) 12 Father's Name (First, Middle, Last) "N/A" HU a. Informant's Name/Relationship (Type DAVID LEATHERY/ SOI	Amed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates: ation completed) College (1-4or 5+) -0-	1 Tea. Decedent's l (Give kind of life. DO NO	s 2 No Sual Occupeti work done du T use retired)	Specify:		Black,	WHITE
treen of Health and Mental H tant: If Item 27 Is marked oth jury or other traumatic even	17. 19a D	(Specify only highest grade (Specify only highest grade) Elementary/Secondary (0-12) 12 Father's Name (First, Middle, Last) "N/A" HU a. Informant's Name/Relationship (Type) DAVID LEATHERY/ SOI	College (1-4or 5+) -0- JEY	(Give kind of life. DO NO	work done du T use retired)	ion Iring most of wor	king	16b. Kind of Busi	ness/industry
treen of Health and Mental H tant: If Item 27 Is marked oth jury or other traumatic even	17. 19a D	Father's Name (First, Middle, Last) "N/A" HU a. Informant's Name/Relationship (Type DAVID LEATHERY/ SOI	JEY	OFFICE					
tment of Health and tant: If Item 27 is ma jury or other trauma	19a D 20a	DAVID LEATHERY/ SOI	e, Print)		,		ne (First, Middle, I		
tment o tant: If jury or		Method of Disposition					ral Route Number		
artme ortan injur	110000	1 ☐ Burial 2 【ACremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	20b. Pla	ace of Disposition (emetery, crematory SAPEAKE CI	Name of or other place;)		20c. Location - C	
Important in survival	21.	Sign re 1 Funerat Bervice Licenses		22. Name	and Address	of Facility	& NEWNAM	4 FUNERL	HOME, P.A.
ysician Medical	lmr dis	a 111. Enter the disease, or complices shock, or heart failure. List only one mediate Cause (Final sease or condition sulting in death)	ation hat caused the death a cause on each line. Due to (or as a consequence)	Do not enter the s	node of dying,	such as cardiad	or respiratory arr	est,	Approximate Interval Betwee Onset and Deat
hysician and the burial-transit as IIcal Examiner	Cau Cau tha res	quentially list conditions, iny, leading to immediate use. Enter Underlying use (Disease or injury at initiated events sulting in death) Last	Due to (or as a consequence of the consequence of t	ypertended of the second of th	ensi Lipia Us 1	conit	A ÍS		
d by the attending phy letached for use as the letached for use as the Physician/Media	IF I	FEMALE: b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	ic. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3 Ectop	ic pregnancy (specify)			23d. Date Mont	of delivery h Day Yea
be c	֓֞֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	rt II. Other significant conditions cont	ributing to death but not resu	ulting in the underlyi	ng cause giver	n in Part I.	23e. Did to		Probably 4 Unk
2 N D							24a. Was a autop perfor 1 Yes	sy pri med2 de	ere autopsy findings ava for to completion of caus lath? Yes 2 \(\sum \text{No} \)
his certific	ນ 25. ດ	. Was case referred to medical examiner? 1 Tyes 2 No	ospital: 1 Inpatient 2 I	ER/Outpatient 3	DOA Other		ath <i>(Check only o</i> ld Home 5 Resid	na) lence 6 ∏Other	(Specify)
After t funera		Manner of Leath Natural 5 Pending Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury Work' 1 🗆 Y	at ? ′es 2 □ No		ow injury occurre	
within 24 hours after death. To the Funeral Director: After t completely filled in by the funera Medical Certification:		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, fa ')	ctory, office	-	28f. Location (S City or Tow		r or Rural Route Number
n 24 hour he Funer pletely filli edical ((Check only one) A. Certifying Physical Examination (Check only one)	ician: To the best of my know er: On the basis of examinat and manner stated.	wledge, death occu tion and/or investiga	rred at the time tion, in my opi	e, date and place inion, death occ	e, and due to the durred at the time, d	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
To the comple		b. Signature and title of contifier			29c. License			29d. Date signed	(Month, Day, Year)
	30	Name of address of person who con	mpleted cause of death (Item	23a) (Type, Print)	DE	2056 part	0 16	Steven	2/06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 16

			1 - State of Mar Registrar		artment of He ertificate of D			iene 6	08028
	*		Decedent's Name (First, Middle, Last)				2. Date of Deal Month	h Day Year	3. Time of Death
	Physici /Medio		Gertrude Wheeler	•			Februar	y 26 200	
	Examir	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I			4c. County of Dea	
_	C		Somerford Assisted Living 5. Social Security Number 6. Sex 7. Age ('In yrs. last birthday			8. Date of Birth	Anne Aru	hplace (State or Foreign
Χ.	Funeral Director		213-12-1411	85 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Jan. 29	, 1921 Ma	ryland
	p ,		Usuel Residence of Decedent 10a, State 10b, County 1	On City Town and					log looks Chilings
	shov	ō		Oc. City, Town or L					10d. Inside City Limits 1 ☐ Yes 2 X No
	28a-1	rect	MD Anne Arunde1 10e. Street and Number	Annapol	10f. Zip Code		1	0g. Citizen of What Co	
	3a or		420 Dewey Drive		214	01		USA	,
036	be filed within 72 hours after death with the Maryland stal Hyglene. ed other than "natural", or Items 23a or 28a-f show event, I're Mudical Examinat must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced 12. Was Decedent Every Armed Forces? 1 Yes 2 Wi No If Yes, Give Year or Dates:	1	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2X No	panic Origin? (Spec , Mexican, Puerto R Specify:	cify Yes or No- lican, etc.)	14. Race - Ame Black, Whit Specify:	
21215-0036	vithin 72 ho ne. han "natur e Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	edent's Usual Occupat e kind of work done du DO NOT use retired)	tion uring most of workin	g	16b. Kind of Business	Industry
	t e g	e Co	12 17. Father's Name (First, Middle, Last)	Homen		18. Mother's Name	(First, Middle, I	Own Home	
Maryland	id be ental ked o	To Be	Curt A. Krumpe			Minna H			
ary	shou and M a mar	F	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street ar			City or Town, State,	Zip Code)
Σ	and 2 saith a n 27 th		Christine L. Friis (Daughte		Dewey Dri			D 21401	
altimore,	t of Ho If iter or oth		20a. Method of Disposition 1XXBurial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispersion of Commetery, cre	osition (Name of ematory or other place) Da		20c. Location - City or	
Ħ,	t. Pag rtmen rtant:		4 □Donation 5 □Other (Specify)		Mem. Gard		_	Davidsonvi	.11e, MD
Ba	permit. Pages 1 and 2 should be fill Department of Heath and Mental H Important: If I tem 27 is marked out any njury or other traumatic even ODCs.		21. Signatur of Funeral Service Licrose	2	Name and Address Hardesty 12 kidgel			A. lis, MD 21	401
	Physician		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	e death. Do not en	nter the mode of dying,				Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	consequence of):	1017100				
***		Examiner	cause. Enter Underlying Cause (Disease or injury	consequence of):					
8760,	ificate be executed g physician and as the burial-transit	edicai Exar	that initiated events ' c	consequence of):					
9	entifica ting pl	Med	IF FEMALE:						
.O. Box	The law requires that the death certificate has been signed by the attending lage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	☐Fetal death 3[□Ectopic pregnancy □ Other (specify)			23d. Date of del Month	ivery Day Year
rds, P	w requires that been signed k should be deta	þ	Part II. Other significant conditions contributing to death but the Delice of the Contribution of the Cont	not resulting in the u	underlying cause giver	n in Part I.		pacco use contribute to es 2 □ No 3 □ Pr	
Records,	hysician: The law re his certificete has bei I director, page 2 sho	Completed	Failure to the	ul			24a. Was a autops perform	y prior to death?	atopsy findings available completion of cause of
/ita	ician: ector,	Be	25. Was case referred to medical examiner?			26. Place of Death	(Check only on	θ)	1
Division of Vital	ng P fter t mera	atlon: To	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 27. Manner of Death 1 ☐ Near of Injury 28a. Date of Injury (Month, Day Y) 2 ☐ Accident investigation		of 28c. Injury Work	4 Nursing Hom		ence 6 Other (Spe ow injury occurred	lesep
Divis	ist or Attendi s after death at Director: A ad in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (- At home, farm, st 'Specify)	treet, factory, office	21	8f. Location (St City or Town	reet and Number or Ri n, State)	ural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (29a. Certifier (Check only one) 1 **X*Certifying Physician: To the best of one in the basis of examiner: On the basis of examiner and manner state.	kamination and/or in	th occurred at the time nvestigation, in my opi	e, date and place, an nion, death occurre	nd due to the ca	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
•	To with Com	2	29b. Signature and little of certifier		29c. License	2728	.2	9d. Date signed (Mont	h, Day, Year)
			30 Name and address of person who completed cause of deal	th (Item)23a) (Type,	Print 1	31 Anno	upolin	MD 21	401
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 1 2006	Signature		I WIT U	1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 116 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 26, 2006 **Physician** Frederick John Waple, Jr. 4:00 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bowie Prince George's 12110 Reardon Lane If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | May 11, 1949 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**2** M 2□ F 56Yrs. WASHINGTON, Director 213-54-9489 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show itsm 27 is marked other then "natural", or items 23a or 28a-f show other treumatic event, I'le Medical Examinar mast be notified at MYYes 2 No Maryland Prince George's Bowie Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12110 Reardon Lane 20715 USA death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nent of Health and Mental Hygiene. snt: If itsm 27 is marked other then "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Naval Research Lab Elementary/Secondary (0-12) College (1-4or 5+) Driver 12th Private Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick John Waple, Sr. Reba Patrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reba P. Waple/ Mother 12110 Reardon Lane Bowie, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Agurial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department of Importent: If any Injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 03/02/2006 Silver Spring, MD. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Hepatitis C 5 yrs. disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last iclan/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) 4 Pregnant at time of death the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\text{Yes} \) 2 \(\text{No} \) No 24a. Was an certificate has 1 Yes 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 5 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this nerel Director: After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Matural 28b. Time of Injury 28d. Describe how injury occurred Certification; 28c. Injury at Work? 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D34403 Feb. 27, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dobin 4175 North Hanson Ct. Bowie, Maryland Dr. Andrew S.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

FEB 2 8 2006

ORIGINAL

32. Registrar's Signature

	1 - For State Registrar	State of Ma	-	Certificate of	Death		Re	eg. No.	6	5 U J U
20	1. Decedent's Name (First, Middle,	Last)					Date of Deat Month	h Day	Year 3.	Time of Death
in ai	LARRY THOMAS Y	OUNG					ARCH			:10 P
er	4a. Facility Name (If not institution,	give street and number)		4b. City, Town,		of Death		4c. County		
	FREDERICK MEMOI 5. Social Security Number		L (In yrs. last birth	FREDER]		24 Hrs. a	Date of Birth	FREDE		/State or Forei
	178-28-9324	1X M 2□ F 69		rs. Months Days			PT 127.	, ^Y 13936	Pennsy	(State or Forei Lvania
	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					10d. li	nside City Limi
jo	Maryland Freder	ick	Freder	ick					1	XYes 2□N
Directo	10e. Street and Number			10f. Zip Code			10	0g. Citizen of W	Vhat Country?	
ai D	70 George Thomas	Drive		2170	2			USA		
Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Decedent of If Yes, specify Cut		igin? (Specify	Yes or No-	14. Race	e - American Ir	ndian,
ģ	1 ☐ Never Married 2 ★ Marne 3 ☐ Widowed 4 ☐ Divorced		0 1957 – 64	1 ☐ Yes 2√2 No			111, 9(0.)	}	White	
Completed	15. Decedent's (Specify only highest	grade completed)	(Decedent's Usual Occu 'Give kind of work done life. DO NOT use retire	during most	t of working		16b. Kind of Bu	usiness/Industr	у
mo	Elementary/Secondary (0-12)	College (1-4or 5+	-	Histology T	echni	cian		Medi	ica1	
BeC	17. Father's Name (First, Middle, Li	ast)		110001067			rst, Middle, N	Maiden Sumam		
To B	Edwin A	Austin Y	oung		Mila	dred		Peck		
-	19a. Informant's Name/Relationshi			Mailing Address (Stree			oute Number,	City or Town,	State, Zip Cod	le)
	Helen Young/Wife	e	70	George Tho	omas Di	rive,	Freder	ick,MD	21702	
	20a. Method of Disposition	_	20b. Place of I	Disposition (Name of crematory or other pla	ace)	Date		20c. Location -	City or Town,	State
	1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			ste Park		3/6/200)6	Altoon	a. PA	
	21. Signature of Funeral Service Li		ATLO-KE	22. Name and Addr		The second second second second				PA
	Sharon C	(1)				Deadi	TCI I			
	23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final	nly one cause on each line	θ.		ssumto ing, such as	cardiac or re			App	oroximate irval Between
icai Examiner	23a. Part1. Enter the disease, or c shock, or heart failure. List o	a. ACUTER Due to (or as a b. Due to (or as a c.	θ.	ot enter the mode of dy FORY FAIL (1): LL LUNG (1):	ssumto ing, such as	cardiac or re			App Inte Ons	
cai	23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infittated events	a. ACUTER Due to (or as a b. Due to (or as a c.	e. CESPIRATE a consequence of a consequence of a consequence of pregnancy Consequence of consequence of	ot enter the mode of dy FORY FAIL (1): LL LUNG (1):	SSUMTO ing, such as CANG	cardiac or re		est,	Applinter Ons	oroximate orval Between set and Death
Physician/Medicai	23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resutting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	a. Due to (or as a b. Due to (or as a d. Due to (or a) d. Due to (or a	e. CESPIRATE a consequence of a consequence of a consequence of pregnancy CESPIRATE CONSEQUENCE OF CON	ot enter the mode of dy TOKY FAIL (1): LUNG (1): 3 Ectopic pregnant 5 Other (specify)	SSUMTO ing, such as CANG	cardiac or re	23e. Did tob	23d. Date Mor	Applinter Ones	oroximate oroxim
by Physician/Medicai	23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	a. Due to (or as a b. Due to (or as a d. Due to (or a) d. Due to (or a	e. CESPIRATE a consequence of a consequence of a consequence of pregnancy CESPIRATE CONSEQUENCE OF CON	ot enter the mode of dy TOKY FAIL (1): LUNG (1): 3 Ectopic pregnant 5 Other (specify)	SSUMTO ing, such as CANG	cardiac or re	23e. Did tob	23d. Date Mor	Applinter Ones	oroximate oroxim
by Physician/Medicai	23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	a. Due to (or as a b. Due to (or as a d. Due to (or a) d. Due to (or a	e. CESPIRATE a consequence of a consequence of a consequence of pregnancy CESPIRATE CONSEQUENCE OF CON	ot enter the mode of dy TOKY FAIL (1): LUNG (1): 3 Ectopic pregnant 5 Other (specify)	SSUMTO ing, such as CANG	cardiac or re	23e. Did tob 1 Ve 24a. Was an autops perforn	23d. Date Mor	Applinter of delivery on the catalog autopsyl for the catalog autopsyl for to complete the the catalog autopsyl for the c	Year use of death? 4 □Unknotindings availation of cause
e Completed by Physician/Medicai	23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a b. Due to (or as a d. Due to (or a) d. Due to (or a	e. CESPIRATE a consequence of a consequence of a consequence of pregnancy CESPIRATE CONSEQUENCE OF CON	ot enter the mode of dy TOKY FAIL (1): LUNG (1): 3 Ectopic pregnant 5 Other (specify)	SSUMTO ing, such as INE	cardiac or re	23e. Did tob 1 Ye 24a. Was an autops: perforn 1 Yes 2	23d. Date More pacco use controls 2 \(\triangle No \) 1 24b. Vivial 2 (1) 2	Applinter Interior of delivery Inth Day Applinter Interior of delivery Inth Day Applinter Interior of delivery Inth Day Applinter Interior of delivery Inthe Day Applinter Interior of delivery Inthe Day Applinter Interior of delivery In	eroximate erval Between eval Between set and Death Argument of the
o Be Completed by Physician/Medical	23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions.	a. Due to (or as a b. Due to (or as a d. Due to (or	e. CESPIRATE a consequence of CESPIRATE a consequence of a consequence o	ot enter the mode of dy TOKY FAIL (i): LUNG (i): 3 Ectopic pregnant 5 Other (specify) the underlying cause g	SSUMT O ing, such as ing. ing. ing. ing. ing. ing. ing. ing.	cardiac or re	23e. Did tob 1 Yes 24a. Was autops: autops: perform 1 Yes 2	23d. Date Mor	Applinter Online	Year use of death? 4 □Unknotindings availation of cause
To Be Completed by Physician/Medical	23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manper of Death	Due to (or as a b. Due to (or as a b. Due to (or as a d. Due to (or as	e. CESPIRATE a consequence of CESPIRATE a consequence of a consequence of a consequence of a consequence of the consequence of a co	ot enter the mode of dy FORY FAIL (1): 3 Ectopic pregnant 5 Other (specify) the underlying cause g	SSUMT O ing, such as ing. such	e of Death Cursing Home	23e. Did tob 1 Ye 24a. Was a autops: perforn 1 Yes 2 heck only one 5 Reside	23d. Date More pacco use controls 2 \(\triangle No \) 1 24b. Vivial 2 (1) 2	Applinter Online	eroximate erval Between eval Between set and Death Argument of the
To Be Completed by Physician/Medical	23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions.	Due to (or as a b. Due to (or as a d. Due to (or as	e. CESPIRATE a consequence of CESPIRATE a consequence of a consequence of a consequence of a consequence of the consequence of a co	obtenter the mode of dy TORY FAIL (1): (2): (3): (3): (3): (4): (5): (7): (7): (8): (8): (9): (9): (1): (1): (1): (1): (2): (3): (4): (4): (5): (7): (7): (8): (8): (9): (1): (1): (1): (1): (2): (3): (4): (4): (5): (6): (7): (7): (8): (8): (9): (1): (1): (1): (1): (1): (1): (2): (3): (4): (4): (5): (6): (7): (7): (7): (8): (9): (9): (1):	SSUMT O ing, such as ing. such	e of Death Cursing Home	23e. Did tob 1 Ye 24a. Was a autops: perforn 1 Yes 2 heck only one 5 Reside	23d. Date More as 2 \(\text{No} \) No \(\text{1} \) Prod? \(\text{2} \) No \(\text{1} \) Prod? \(\text{2} \)	Applinter Online	Year use of death? 4 □Unknotindings availation of cause
To Be Completed by Physician/Medical	23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Due to (or as a b. Due to (or as a b. Due to (or as a d. Due to (or as	e. CESPIRAT a consequence of CESPIRAT a consequence of a cons	obtenter the mode of dy TORY FAIL (1): (2): (3): (3): (3): (4): (5): (7): (7): (8): (8): (9): (9): (1): (1): (1): (1): (2): (3): (4): (4): (5): (7): (7): (8): (8): (9): (1): (1): (1): (1): (2): (3): (4): (4): (5): (6): (7): (7): (8): (8): (9): (1): (1): (1): (1): (1): (1): (2): (3): (4): (4): (5): (6): (7): (7): (7): (8): (9): (9): (1):	SSUMTO ing, such as ing, such as ing. Sum to order them and ing. Sum to order them are also ing. Sum to order them are also ing.	e of Death Cursing Home	23e. Did tob 1 Ye 24a. Was an autops: perform 1 Yes 2 heck only one 5 Reside	23d. Date More as 2 \(\text{No} \) No 1 1 e) ance 6 \(\text{Otherwinjury occurrent} \)	Applinter Online	Year use of death? 4 Unknotindings availation of cause
Certification: To Be Completed by Physician/Medical	23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a b. Due to (or as a b. Due to (or as a d. Due to (or	e. CESPIRAT a consequence of CESPIRAT a consequence of CESPIRAT a consequence of a consequence	ot enter the mode of dy TORY FAIL (i): LUNG (i): 3 Ectopic pregnant 5 Other (specify) the underlying cause g the underlying cause g patient 3 DOA O me of 28c. Injury M 1 m, street, factory, office death occurred at the index of the index o	ssumt of ing, such as ing, such as ing. such	e of Death Cursing Home 28d. No 28f.	23e. Did tob 1 Ye 24a. Was an autops: perform 1 Yes 2 heck only one 5 Reside Describe ho Location (Str. City or Town	23d. Date More More Part of the More More Part of the Mor	Applinter One of delivery Interest of delivery Inte	Year use of death? 4 □Unkno indings availation of cause No
To Be Completed by Physician/Medical	23a. Part1. Enter the disease, or cashock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a b. Due to (or as a b. Due to (or as a d. Due to (or as	e. CESPIRAT a consequence of CESPIRAT a consequence of CESPIRAT a consequence of a consequence	ot enter the mode of dy TORY FAIL (1): (2): (3): (3): (3): (4): (5): (7): (7): (8): (9): (9): (9): (9): (1): (9): (1): (1): (1): (2): (3): (3): (3): (4): (5): (7): (7): (8): (8): (9): (9): (1): (1): (1): (1): (1): (1): (2): (3): (4): (5): (6): (7): (7): (8): (8): (9): (9): (1): (1): (1): (1): (1): (2): (3): (4): (4): (5): (5): (6): (7): (7): (8): (8): (9): (9): (1): (1): (1): (1): (1): (1): (2): (3): (4): (4): (5): (6): (7): (7): (7): (8): (9): (9): (1):	ssumt of ing, such as ing, such as ing. such	e of Death Cursing Home 28d. No 28f.	23e. Did tob 12Ye 24a. Was an autops: perform 1 Yes 2 heck only one 5 Reside Describe ho Location (St. City or Town due to the cat the time, da	23d. Date More More Part of the More More Part of the Mor	Applinter Online	Year wse of death? 4 Unkno indings availation of cause No
edical Certification: To Be Completed by Physician/Medical	23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a b. Due to (or as a b. Due to (or as a d. Due to (or	e. CESPIRAT a consequence of CESPIRAT a consequence of CESPIRAT a consequence of a consequence	at enter the mode of dy TOKY FATIL (1): 3 Ectopic pregnant 5 Other (specify) the underlying cause g catient 3 DOA me of 28c. Injury M 10 m, street, factory, office death occurred at the electory of investigation, in my 29c. Licer	cy 26. Place ther: 4 Nu ny at ork? Yes 2 1	e of Death C. ursing Home 28d. No 28f.	23e. Did tob 12Ye 24a. Was an autops: perform 1 Yes 2 heck only one 5 Reside Describe ho Location (St. City or Town due to the cat the time, da	23d. Date More More as 2 No n 24b. V n n 24b. V n n 24b. V n n n 24b. V n n n n n n n n n n n n n n n n n n	Applinter Online	Year wse of death? 4 Unknot indings availation of cause No
edical Certification: To Be Completed by Physician/Medical	23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a b. Due to (or as a b. Due to (or as a d. Due to (or	e. CESPIRAT a consequence of CESPIRAT a consequence of CESPIRAT a consequence of a consequence	at enter the mode of dy TOKY FATIL (1): 3 Ectopic pregnant 5 Other (specify) the underlying cause g the underlying cause g attention 3 DOA The of 28c. Initiative M 15 The street, factory, office death occurred at the learn of the learn occurred at the learn of the learn occurred at the learn occurred occurred at the learn occurred at the learn occurred occurred at the learn occurred at the learn occurred occurred at the learn occurred	cy 26. Place ther: 4 Nu ury at ork? Yes 2 1	e of Death C. ursing Home 28d. No 28f.	23e. Did tob 12Ye 24a. Was an autops: perform 1 Yes 2 heck only one 5 Reside Describe ho Location (St. City or Town due to the cat the time, da	23d. Date More More as 2 No n 24b. V n n 24b. V n n 24b. V n n n 24b. V n n n n n n n n n n n n n n n n n n	Applinter Online	Year wse of death Unknown indings availation of cause No

			For State Registrar	State	of Marylai	-	artmer <i>rtificat</i>				ental Hyg	iene	06	08031
	50 ×	v.	1. Decedent's Name (First, Middle, I	.ast)							2. Date of Deat Month	h Day	Year	3. Time of Death
	Physici /Medio		Edith Irene	Step	hens						Februar			10:25 ^{p м}
)	Examir		4a. Facility Name (If not institution, g	ive street and nu	ımber)				Location of				nty of Death	
			Bedford Court						Sprin			Mo	ontgom	
\$1. 15 c	Funeral		5. Social Security Number 6. 252-05-8452	.Sex 1 ☐ M 2 欠 F	7. Age (In yrs	. last birthday) 92 Yrs.	Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day,	Year)	Cou	
4.5	Director		Usual Residence of Decedent			52					Oct. 18,	1913	Ala	ıbama
	/land		10a. State 10b. County		10c. C	ity, Town or Lo	ocation							10d. Inside City Limits
	Man Firsh	tor	Maryland Montgo	omery		Silver	Sprin	ıg						1 ☐ Yes 2 No
	h the	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen o	of What Cou	intry?
	15 will will will will will will will wil		3700 Internation	onal Dri	ve, #2]	L1	20	906				USZ	Α	
36	should be filed within 72 hours after death with the Maryland Montal Hygiene. marked other than "natural" or Items 23e or 28e-f show imatic event, Ita Mudical Exercities mast ke notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ XWidowed 4 □ Divorced	Armed F	2√∑No ive		Was Dece If Yes, spe 1 Yes	cify Cuba	ispanic Ori in, Mexican Specify:	n, Puerto I	crify Yes or No- Rican, etc.)	8	Race - Amen Black, White, acify: Whi	etc.
ž	2 hou	ted	15. Decedent's	Education		16a. Dece	dent's Usu	al Occupa	ation			16b. Kind of	f Business/In	ndustry
2 2	filed within 72 Hygiene. other than "nai	Completed	(Specify only highest of Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT u	se retired	during mos	t ot workii	ng			
7	gien et fa	NO.	12			Ac	count	ing	Clerk	2		Airl:	ine	
9	tal Hy d oth	0	17. Father's Name (First, Middle, La	st)							(First, Middle, I	Maiden Sum	iame)	
<u>X</u>	Menidia	၉	Unknown Sharpton							Sharp				
, Maryland 21215-0036	and 2 sh aith and 127 is m er traum		19a. Informant's Name/Relationship Toni Lieberman/		r		•				Potoma			
Baitimore,	permit. Pages 1 and 2 should by Deperment of Health and Menta Important; if Item 27 is marked any Injury og other traumatic ence.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		State	Place of Dispo cemetery, cre orge Was	matory or	other plac		Marc	h 3,		on-City or T i, Mar	
	pertme sortan / Injug		21. Signature of Funeral Service Lice								Funeral			y rane.
'n	8 5 5 6		John John	٤.(ع	South	$$ $\frac{\mathbf{f}}{5}$	00 Ur	iver	sity	Blvd	l, W, Si	lver	Spring	, MD 20901
*	Physician /Medical Examiner		23a. Part1. Enter the disease, or conshock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a	(or as a conse	quence of):	AR T	ER	g, such as	SE ISE	ASE	est,		Approximate Interval Between Onset and Death
8/60,	The taw requires that the death certificate be executed the bas been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dicai Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conse									
٥	ng ph	Med	IF FEMALE:											
O. Box	that the death certificated by the attending properties of the action of	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	utcome of pregr birth 2 Fet mant at time of nown	al death 3	Ectopic p Other (s)						Date of deliv Month	very Day Year
Records, P	uires that signed b		Part II. Other significant conditions HYPE	RTEN	S 10N	sulting in the u	ınderiying	cause give	en in Part I			oacco use c		the cause of death?
<u> </u>	w require been sign	Completed	(0)	d'							24a. Wasa	n 24	b. Were aut	opsy findings available ompletion of cause of
	sicien: The taw certificate has i irector, page 2 s	E									autops perform	ned?	prior to co death? 1 \(\sum \text{Yes}	
VItal		a)	25. Was case referred to medical	1					26. Place	e of Death	(Check only on		1 103	166.675
>	nysic is ce direc	To B	examiner?	Hospital:	Inpatient 2] ER/Outpatie	nt 3 D	Oth Oth	er: 4 🗌 Nu	ursing Hor	me 5 Reside	nce 6	Other (Spec	(b) 1 (1) NG
n O	ng Ph fter th neral		27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time o	of .	28c. Injun Wor	y at k?	2	28d. Describe ho	w intury oc	curred	LIVINO
20	sndii eath. or: A the fu	catio	2 ☐ Accident investigat				М		Yes 2	No				
DIVISION	pitel or Attanding Pours efter death.	Certification:	3 Suicide 6 Could not	28e. Plac	e of Injury - At I ling, etc. (Spec	home, farm, st ify)	reet, factor	y, office			28f. Location (St City or Town		imber or Rui	ral Route Number,
	Hog H P P	Medical	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the aminer: On the and man	e best of my kn basis of examin nner stated.	nowledge, deat action and/or in	h occurred evestigation	at the tin	ne, date an pinion, dea	nd place, a ath occurre	and due to the ca ed at the time, d	ause(s) and ate and plac	manner as	stated. to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifie		1	7 -	29	c. Licens	number 8	100	2		gned (Month	
)	1			/ //	1			ソン	>04	(7)		Febr	uary 2	27, 2006
	(30. Name and address of person with Nakul Goyal, M.	o completed cau D. 3801	se of death (Ite Interr	em 23a) (Type nationa	Print) 1 Dri	lve,	#211,	, Sil	ver Spr	ing,	Md 209	906
- A. C.	Sta Registr		31. Date filed (Month, Day, Year)		Registrar's Sign	nature	A.F					-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 6

			1 - For State Registrar	State Of Ma	iryland / L	Certificate of	Death		elien n P	00002
*.	n.		1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month	Day Year	3. Time of Death
1	Physic /Medi		Moshe Shore	<u> </u>				Februar		1:00 P. M
	Examir		4a. Facility Name (If not institution, given	re street and number)		4b. City, Town,	or Location of Deat	h	4c. County of Deat	
		t only	Hebrew Home of (.=	Montgom	ery
	Funeral Director		5. Social Security Number 6. 8	Sex 7. Age	(In yrs. last birti	Months Dave			9. Birt Co	hplace (State or Foreign untry) Israel
	yland wow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Ba-1sh	Director	Maryland Montgon	nery	Rockvi	11e				1∏Yes 2∏No X
	or 24	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	ath v	a	6121 Montrose Roa	T			20852		U.S.A	. •
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itama 23e or 28e-1 show among injuryang other traumatic evant, it a Medical Evantinal must be recitied at anone.	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Tyes 2 PN If Yes, Give Year or Dates:		13. Was Decedent of I If Yes, specify Cub		Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify: W	
ş	2 hou		15. Decedent's E	ducation	16a.	Decedent's Usual Occup	pation	1	6b. Kind of Business/	
2 2	within 7.	Completed	(Specify only highest grant (0-12)	Completed) College (1-4or 5-4 4 Years		(Give kind of work done life. DO NOT use retire Cantor	during most of wo d)	rking	Synagogu	,
7 0	Hygie ther nt, II	e Co	17. Father's Name (First, Middle, Last			Gaireot	18 Mother's Na	me (First, Middle, M		
yland	d be ental	To Be	Eliezer Shear				unknown		alden Sumame)	
<u></u>	Shoul nd Me mark	ř	19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address (Street			City or Town State 2	in Code O / OO 7
<u>8</u>	lith ar 27 is 7 trau		Ariel A. Shore -	**		5 Connemara				,
ā,	f Heal	1	20a. Method of Disposition		20b. Place of	Disposition (Name of			Oc. Location - City or	
Dalitimor	riment o		1.X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	y)		r, crematory or other pla unt Lebanon	2/26		Adelphi, M	-
D	Depa Impo any i		21. Signature of Funeral Service Licen	1500		Danzansky 1170 Rockv	Goldberg	Memorial	Chapels,	Inc. and 20852
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused to	he death. Do no					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			ial Inforat				Onset and Death
	/Medical		resulting in death)		consequence o	ial Infarct ^{n:}				
	Examiner		Sequentially list conditions	b Corona	rv Arte	ry Disease				
	₽ ≒	iner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence o	():				
	ecute and trans	Examiner	that initiated events resulting in death) Last	c						
0000	rificate be executed g physicien and as the burial-transit			Due to (or as a	consequence of	r):				
000	flicate p phys ts the	Medicai		. d	1770					
.O. DO.	Attanding Physician: The law requires that the death certificate be executed to death. r death. stor: Atter this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at to 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	/		23d. Date of deli Month	very Day Year
Ľ	s that ined b e deta	by Pł	Part II. Other significant conditions of	ontributing to death but	not resulting in	the underlying cause giv	ren in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Š	w require been sig should b	ted t	Hypertension					1 ☐ Yes	2 № 3 □ Pro	bably 4 Unknown
שבו ויי	ding Physician: The law h. h. After this certificate has b funeral director, page 2 st	Completed	Diabetes Mell	itus - Typ	e 2			24a. Was an autopsy perform 1 ☐ Yes 2	prior to c	copsy findings available ompletion of cause of
	ician Sertifi ector	Be	25. Was case referred to medical examiner?	Hospital				th Check only one		
5	Phys this al dir	2	1 ☐ Yes 2 🏋 No 27. Manner of Death	Hospital: 1 ☐ Inpatien		patient 3 DOA Oth	4 (A Muising I		ce 6 □Other (Spec	ıfy)
5	ding h. After funer	ion	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Tii	ury Wor		28d. Describe hov	v injury occurred	
2	Attandi death. ctor: A y the fu	fica	2 Accident investigation 3 Suicide 6 Could not b		v - At home, farr	n, street, factory, office	Yes 2 □No	28f Location (Stre	et and Number or Ru	ra I Pauta Number
2	ital or / rs after rai Dire	Certification;	4 Homicide determined	building, etc.	(Specify)			City or Town,	State)	
	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the to	dicai	29a. Certifier (Check only one) Certifying Ph 2 Medical Exam	ysician: To the best of timer. On the basis of a and manner state	xamination and	death occurred at the tir or investigation, in my o	ne, date and place pinion, death occu	, and due to the cau rred at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
	To th To th Comp	Me	29b. Signature and title of certifier			29c. Licens	e number	290	d. Date signed (Month	. Day, Year)
	6		Muln	Je 1 mg	Im.	√7 D 1	8084	Fe	ebruary 22	, 2006
			30. Name and address of person who Dinesh Patel, M			ype, Print)			20852	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 2 2	0.0 #		4	EVILLE, I	iai y Lanu	20072	
	riegistr	at		AND DOOR		7				

			1- State of Maryland / Depa	tificate of De			ene g. No: 0 0	08033
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	3. Time of Death
	/Medic		Beverly Virginia Sackville			Februar	y 27, 2	2006 6:06 P M
>	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Loc			4c. County of	
			Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday)	Silver S		0.0	Montgo	
Ì	Funeral Director		5. Social Security Number 225-30-2411 Usual Residence of Decedent 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 77 Yrs.		ours Min.	8. Date of Birth (Month, Day, Sept. 24	(ear) , 1928	9. Birthplace (State or Foreign Country) Washington, D
	land ww		10a. State 10b. County 10c. City, Town or Loc	cation				10d. Inside City Limits
	death with the Maryland ms 23s or 28s-f show rmast be notified at	tor	Maryland Montgomery Silver S	pring				1 ☐ Yes 2x No
	h the	Director	10e. Street and Number	10f. Zip Code		10	g. Citizen of W	/hat Country?
	th wit		8712 Colesville Road, Apt. 209	20910			US	SA
	dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. W Armed Forces? 13. W	Vas Decedent of Hispar Yes, specify Cuban, M	nic Origin? (Spe	cify Yes or No-		e - American Indian, k, White, etc.
036	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or Itema 23a or 28a-f show event, the Medical Examinar must be notified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	☐ Yes 2 1 No Sp		noun, otoly		: White
ဂ ဂ	72 hc	eted	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give k	ent's Usual Occupation	a most of working	10	6b. Kind of Bus	siness/Industry
Maryland 21215-0036	within 72 lene. than "nat	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ind of work done during ONOT use retired)			reacho.	Government
0	filed Hygid Sther ent,		17. Father's Name (First, Middle, Last)			(First, Middle, Ma		
<u>a</u>	id be ental ked c	To Be	Nelson Alan Pixton	Ce	ecilia 1	Regina B	laden	
2	2 should be and Mental is marked reumatic ev	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and I				State, Zip Code)
	es 1 and 2 should b of Heelth and Ment litem 27 is marked r other treumatic e		10 10					
စ်	Hee Hee tem othe		20a. Method of Disposition 20b. Place of Dispos	Colesville	D:	ate 20		City or Town, State
2	y or H		1 □ Burial 2 ☑ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitar	atory or other place) 1. Crenatory	March 200		lovandr	ia, Virginia
Baitimore,	artme orten injur			-				
n	permit. Pages Department of t importent: If ite any injury or of		Ken Skle 500	ancis J. Co O Universit	olTins E ty Blvd,	Tuneral I W, Sil	Home In ver Spr	nc ring, MD 20901
П			23a. Pag1. Enter the disease; or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	r the mode of dying, su	ich as cardiac or	respiratory arres	t,	Approximate
	Physician		Immediate Cause (Final	atory Arro	~+			Interval Between Onset and Death
,	/Medical		disease or condition resulting in death) ACULE CATGLOTESPITS Due to (or as a consequence of):	acory Arres	5.6			
	Examiner		Ischemic Heart Dise	ease				
	200	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hypertensive Heart					
	outed od ransii	Examiner	Cause (Disease or injury that initiated events Hypertensive Heart	Disease				
ĵ	en ar en ar rial-tı	EX	resulting in death) Last Due to (or as a consequence of):					
08/00	tificate be executed g physicien and as the burial-transit	edical	Arteriosclerotic He	eart Diseas	se			
	ng pt		IF FEMALE:					
.O. BOX	w requires that the death cert been signed by the attendin should be detached for use	Physiclan/N	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy Other (specify)			23d. Date Mont	e of delivery th Day Year
, Č	requires that the een signed by th nould be detache		Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in	Part I.	23e. Did toba	cco use contrib	bute to the cause of death?
ğ	en sig	edt	Chronic Obstructive Pulmonary Disease			1 [¥] Yes	2 □ No 3	3 Probably 4 Unknown
Hecords	sician: The law re certificate hes be irector, page 2 sh	Completed by				24a. Was an autopsy performe	d? de	Vere autopsy findings available rior to completion of cause of eath?
VII G	an: Tifica tor, p	0	25. Was case referred to medical	26	Place of Death	1 Yes 22 Check only one	INO 1L	Yes 2 No
>	> 20	0 8	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient			e 5 Residen	ce 6 ∏Other	r (Specify)
5	g Physical dispersal dispe	Ë	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at Work?		Bd. Describe how		
2	ath. r: Aff	atio	1 ■ Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	M 1 ☐ Yes	2 □No			
DIVISION	To the Hospitel or Attending Planthin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office	2	8f. Location (Stre City or Town,		r or Rural Route Number,
	pitel ours a eral [Constitution Devices Total Action Constitution Devices Total Action Constitution Co					
	Hos 124 ho 16 Fundately f	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Physicien: To the best of my knowledge, death of the basis of examination and/or investing and manner stated.	occurred at the time, da estigation, in my opinion	ate and place, ar n, death occurre	nd due to the cau d at the time, date	se(s) and man and place, ar	ner as stated. nd due to the cause(s)
	Withir To th	Me	29b. Signature and title of certifier	29c. License num	nber	29d	. Date signed	(Month, Day, Year)
	4		E le Vaugh Betton	D0481	.4	Fe	bruary	28, 2006
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Pi		C11:+-	334 1.7	ah i i	DG 00000
	Sta	te			, suite	334, Wa	sningto	on, DC 20009
	Registra	-	31. Date filed (Month, Day, Year) MAR 0 2 2006	- GL				

			1 - For State Registrar	State of Maryland		artment of F		_	giene Reg. No. 0 0 6	080	134
	Physici /Medi		1. Decedent's Name (First, Middle, Last	Bussell	/			2. Date of De Month	Day Y	aar -	of Death
}	Examir	ner	4a. Facility Name (If not institution, give Manor Care Nur. 5. Social Security Number 6. Se	sing Home	ant historia d		r Location of Death Spring			gomery	
	Funeral Director			7. Age (In yrs. In 94	Yrs.	Months Days	Hours Min.	(Month, Da	y, Year) 5-1911	. Birthplace (State Country)	∍ or Foreign
	n the Marylan r 28e-f show incliffed at	Director	DC 10b. County None	747	, Town or Lo 'ashir				10g. Citizen of Wha		City Limits es 2 ☐ No
336	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f show ha Medical Examinar must be notified at	by Funeral	1286 Morse Str 11. Marital Status 1 Never Married 2 Married 3X Widowed 4 Divorced	eet N.E. 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2▼No If Yes, Give Year or Dates:		2000 3 Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 No		pecify Yes or No Rican, etc.)		SA American Indian, White, etc. Black	
Maryland 21215-0036	75 75 10 100	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	cation e completed) College (1-4or 5+)	(Give life. i	dent's Usual Occupi kind of work done of DO NOT use retired	during most of won		16b. Kind of Busin		ry
yland	0 m 2 >	To Be	17. Father's Name (First, Middle, Last) John Robert Pe				Carolin	ie	Maiden Sumame)	Peacoc	ck
45	and 2 ealth a m 27 ls		19a. Informant's Name/Relationship (7) M. Naonia Washi Legal Guardian 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Dogation 5 ☐ Other (Specify)	20b. Pla Removal from State	4919 ace of Dispo		reet NW	I; Wash	er, City or Town, Sta DC 2 20c. Location - Cit Landove	0011 y or Town, State	
Baltir	permit. Pages 1 Department of H Important: If itel any injury or ott		21. Signature of Fureral Service Licens		22	. Name and Addres	ss of Facility	2	831 Geo ashingt		7e. NW 20011
8760,	Physician and ph	dical Examiner	23a Part1. Enter he disease, or comply shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence). Due to (or as a consequence). Due to (or as a consequence).	Po not ent. Vak ence of): 1 ence of):	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,	Approxim Interval Bi Onset and	ate etween
.O. Box 68	ne death certif the attending thed for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{2No} \) 9 \(\text{Unknown} \)	3c. If yes, outcome of pregnan 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date o Month	f delivery Day	Year
<u>α</u>	faw requires that the as been signed by	þ	Part II. Other significant conditions con	ntributing to death but not result	lting in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use contribu		f death?]Unknown
Vital Records,	The ate h page	e Completed	25. Was case referred to medical	•					sy prior deat 2 No 1		s available cause of
Division of Vil	d is	ToB	examiner? 1 Yes 2	dospital: 1 Inpatient 2 E 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	at	ome 5 Resid	ne 6 □Other (ow injury occurred	Specify)	
DİXİ	pital or Att urs after d erel Direct illed in by i		4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)			ne ne	City or Tow			mber,
	To the Hospital or Attending Phywiting 2 hours after death. To the Funerel Director: After the completely filled in by the funeral	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier	sician: To the best of my knowner: On the basis of examination and manner stated.	rledge, death on and/or inv	restigation, in my op	pinion, death occur	red at the time, o	date and place, and	due to the cause	
	Sta	te	Darry (31. Date filed (Month, Day, Year)	mpleted cause of death (Item : 36)	35	Balti	mre	Ave.	2/28 nue,	Lame	PMD
	Registr	ar	MAR 022	006	17						

Registrar DHMH 17 Rev 1/2001

State

were

02

Anuradha Arun,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.1

M.D.

2006

Cum, M.D

D57630

10301 Georgia Avenue, #209, Silver Spring, MD 20902

February 28, 2006

06--1333 B.K.S SAFIYAH YASMEEN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

RASHID	State of Maryland / Department of Health and
State Registrar	Certificate of Death

Mental Hygiene 18036

			- State Registrar		Cer	tificate of L	<i>Jeath</i>		Reg. No.	U	9999	7 (7	
	Physici	an	Decedent's Name (First, Middle, Last)	_				2. Date of De Month FEB	Day	Year	3. Time of E		
	/Medic					k-Rashid				22, 2006		Рм	
	Examin	4/OI B ROOKEWOOD PLACE				4b. City, Town, or Location of Death WALDORF			4c. County of Death				
	Funeral Director		370-00-9907	7. Age (In yrs. la 25	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da 10/7/	y, Year) 1980	9. Birthplace (State or Foreign Country) 80 Washington, DC			
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lor	cation					IOd. Inside City	Limits	
	Maryi f sho	ō	MD Prince G	eorges Tem	ple	Hills					1 🗌 Yes	2 X No	
	r 28s	lrec	10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?				
	15 with with 23 a o	Funeral Director	3809 26th Ave.			20748			U.S.A	•			
	tems	nue	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?		 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 			ecity Yes or No Rican, etc.)	- 14. Ra Bla	14. Race - American Indian, Black, White, etc.			
9500	ours after	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 2 🛣 No If Yes, Give Year or Dates:	1	☐ Yes 2X No	Specify:		Speci	fy: bla	ick		
,	72 h	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced (Give	lent's Usual Occupa kind of work done d	tion uring most of worki	ng	16b. Kind of I	Business/In	dustry		
7	within	ш	Elementary/Secondary (0-12)	College (1-4or 5+)		iife. DO NOT use retired) unemployed			ne	none			
7	Hygie Hygie Int.		17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,					
2	lid be lental ked c	To Be	Soloman Malik				Shei	la De	nnis				
ary	shou and M s mar	-	19a. Informant's Name/Relationship (Typ		19b. Mailin	g Address (Street a	nd Number or Rura	l Route Numbe	er, City or Town	n, State, Zip	Code)		
<u> </u>	and 2 palth n 27 I		Sheila Dennis/			Vistul						0744	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Any injury or other traumatic event, the Medical Examination must be notified at once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	cer	metery, crem	sition <i>(Name of</i> na <i>tory or other pl</i> ace .coln Cel	9)	8/06	20c. Location Brenty				
Dallillor	Depertment of the post of the		21. Signature of Funeral Service Vicense	A 064		. Name and Addres	0.	nivers	al Mor	tuar	·y		
	40240		23a Part 1 Enterine disease or complic	0.700.0		11 Kenn				ngto	Approximate	0011	
	nysician /Medical Examiner	resulting in death) Due to (or as a consequence of):											
,00,00	certificete be executed nding physicien and use as the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque									
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours attent deeth within 24 hours attent deeth within 25 to the Furnated Director. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)						23d. Date of delivery Month Day Year			
ר יטא	juires that rigned t	þ	Part II. Other significant conditions conf							use contribute to the cause of death?			
	law req es beer 2 shou	Completed			24a. Was								
	The sete h page	Con						1 Yes	rmed?	death?			
110	cian: sertific actor,	Be	25. Was case referred to medical examiner?			100	26. Place of Death	(Check only o					
5	Physic this cral dir	- To	Yes 2 No 13 No 27. Manner of Death	ospital: 1 ☐ Inpatient 2 ☐ E 28a. Date of Injury (Month, Day Year)	R/Outpatien	t 3 DOA Othe 28c. Injury Work	4 Nursing Ho		dence 6.XIOt		y) AT SC	ENE_	
5	ding th. After fune	Certification:	1 ☐ Natural 5 ☐ Pending	? 'es 2 No		c+ 5/	07						
DIVISION	Atten r deel octor; y the	fica	2 Accident 3 Suicide 4 Homicide investigation 6 Could not be determined 2 22 00 6 2 28e. Place of Injury - At home, farm building, etc. (Specify)			- 80			Street and Num	and Number or Rural Route Number,			
5	s after	Cert							elwood	ate)			
	Hospit 24 hour 24 hour Funera etely fille	edicai (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my know er: On the basis of examination	ledge, death on and/or inv	occurred at the tim restigation, in my op	e, date and place, inion, death occurr	and due to the	cause(s) and π	anner as s , and due to	tated. the cause(s)		
	To the vithin To the somple	Me	29b. Signature and title of certifier	1		29c. License			29d. Date sign				
	3	labrule Ae- O.C.M.E FEB. 23								23, 20	2006		
			30. Name and address of person who cor	mpleted cause of death (Item 11		Print) N STREET,	BALTIMOR	E, MARYI	AND 21:	201			
	Sta	40	31. Date filed (Month, Day, Year)	32. Degistrar's Signatu	ıre .								

State

Registrar

MAR 0 2 2006

			Please	• -	nt in Black In				_			
			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F ertificate of		ental Hygiei Reg.	C 0 0 0	08037		
			Decedent's Name (First, Middle, Last	st)				2. Date of Death	_	3. Time of Death		
	Physicia /Medic		Dionne Shree' (opeland J	ohnson		I	ebruary	26, 2006	7:25 A ^M		
}	Examin		4a. Facility Name (If not institution, give	street and number)			r Location of Death		4c. County of Dea	th		
			Holy Cross Hospi			Silver			Montgo			
	Funeral		5. Social Security Number 6. S 435–19–7997	ex 7. Ag □M 2⊡xF	e (In yrs. last birthday 37 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye April 7,	ar) Co	thplace (State or Foreign ountry)		
	Director	-	Usual Residence of Decedent				<u> </u>	April 7,	1900 LC	ouisiana		
	yland		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits		
	a-1-i	ctor	Louisiana N/A		New Orl	eans				1X Yes 2 □ No		
	or 28	Sire.	10e. Street and Number			10f. Zip Code			Citizen of What Co	-		
	s 23a	by Funeral Director	9021 Forshey Str			70118			nited Sta			
	er de Items	Tue	11. Marital Status 1 ☐ Never Married 2X Marned	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🔯		If Yes, specify Cub	lispanic Origin? (Spe an, Mexican, Puerto F	Rican, etc.)	Black, White			
36	ir, or	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify:	n American		
21215-0036	within 72 hours after deeth with the Maryland ane . then "naturel", or items 23a or 28a-f ehow he Moslest Exercifier must be notified at	ted	15. Decedent's E		16a. Dec	edent's Usual Occup	pation	166	. Kind of Business			
218	thin 7	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or !	5+)		during most of working)					
21	ygien ygien rer th	ပ္ပ			Res	earch Spe	cialist 18. Mother's Name		Bank			
pu	be fill d oth	Be	17. Father's Name (First, Middle, Last, Jimmie Chester C				Anna Pi		den Sumame;			
Maryland	hould d Mer mark maric	ပ္	19a. Informant's Name/Relationship (•	19h Mai	ling Address (Street	and Number or Rura		tv or Town. State.	Zip Code)		
S	d 2 s th an trau		Anna P. Copeland	(Mother)			Street, Ne			0118		
	Heel Heel		20a. Method of Disposition	·	20b. Place of Disp		D		Location - City or			
E	in in its		1 ☑ Burial 2 ☐ Cremation 3 🛭 4 ☐ Donation 5 ☐ Other (Specif			Cemetery		006 A	vondale,	LA		
Baltimore,	10a. State 10b. County 10c. City, Town or Location 10c. City Code 10c. City											
ä	80 E 8		Undre	Thony	oson	7400 Geor	gia Ave. N	.W., Was	h. D.C.	20012		
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Metasta Due to (or as	atic Neuro a consequence of):					Approximate Interval Between Onset and Death		
68760,	certificate be executed rding physiclen end ise as the buriel-transit	Aedical Examiner	Cause (Disease or Infury that initiated events resulting in death) Last	CDue to (or as	a consequence of):							
.O. Box	deeth e atter id for u	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death 3	☐Ectopic pregnanc ☐ Other (specify) _	у		23d. Date of de Month	livery Day Year		
rds, P	8 5 9		Part II. Other significant conditions	contributing to death t	out not resulting in the	underlying cause gr	ven in Part I.	- 11, 20		o the cause of death? robably 4 Unknown		
I Records,	e law r hes be je 2 sh	Completed						24a. Was an autopsy performed	prior to death?			
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Line and i			26. Place of Death					
f	Physic this c	2	1 Yes 2 XNo		ent 2 ER/Outpati		her: 4 Nursing Hor	ne 5 Residenc		ecify)		
L C	ng ffer ine	lon	27. Manner of Death 1 ☐Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of fnji (Month, Da	ury 28b. Time ln fury	Wo	rk?]Yes 2 □No	od, Describe now	infully occurred			
Division	To the Hospital or Attendi within 24 hours effer death. To the Funerei Director: A completely filled in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not to 4 Homicide determined	28e. Place of In	jury - At home, farm, s tc. (Specify)			28f. Location (Stree City or Town, S	t and Number or F State)	lural Route Number,		
	ne Hospita 124 hours 18 Funerel letely filled	Medical C			of my knowledge, dea of examination and/or tated.							
	withir To th comp	Me	29b. Signature and title of certifier	0 1.	(1 1 0	29c. Licen	se number	29d.	Date signed (Mon	th, Day, Year)		
	7		Kohah	y n	uy	D608	26	Fe	ebruary 2	7, 2006		
	(30. Name and address of person who									
			Kshama Gargg, M.	20 0	Forest Gle		ilver Spri	ng, MD	20910			
	Sta Regist		31. Date filed (Month, Day, Year) MAR 0 2	2006 32. High	rar's Signature	porte						

			1 = For Stete Registrer 1. Decedent's Name (First, Middle,		of Maryla	and / Dep Ce	artme rtifica	nt of H	ealth and Death	Mental Hy	Reg. No.	006	080	38
- S /	ysicia Nedic	al	GEORGE 4a. Facility Name (If not institution,	O.	GRAY	ζ	41.00			Month Februar	Day 27			A
Fun Dire		ev.	Montgomery C 5. Social Security Number 579-10-6317		Hospi	ital rs. last birthday) Yrs.		Oln er 1 Year	Location of Dea EY If Under 24 Hr Hours Mir	s. 8. Date of B	nth ay, Year)			
r 28e-f ehow	notified at	Director	Usual Residence of Decedent 10a. State 10b. County MD Montg 10e. Street and Number	omery	10c.	City, Town or Lo	vil	le				en of What Cou	10d. Inside C	ity Limits
Iryland Z1Z15-UU36 should be filed within 72 hours after death with the Maryland to Mental Hygiene. marked other than "natural", or Iteme 23a or 286-1 ehow	exacting must be	by Funeral	18544 Queen 11. Marital Status 1 Never Married Marrie 3 Widowed 4 Divorced	12. Was Dec Armed F	cedent Ever in orces? XXNo ive	U.S. 13.	Was Dec	2083		Specify Yes or Norto Rican, etc.)	D- 14	J.S.A. 4. Race - Ameri Black, White	can Indian, etc.	
C 21215-0036 filed within 72 hours at Hygiene. ther than "naturel", or	ont, the Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 10th 17. Father's Name (First, Middle, La	grade completed College) (1-4or 5+)	(Give	kind of w DO NOT	erato	or or		Mont Publ	of Business/in gomery ic Sch	dustry 7 Cour	nty
	raumatic eve	0	Oliver B. 19a. Informant's Name/Relationship	Grav (Type, Print)		19b. Mailin	g Addres		24.4	ame (First, Middle Je Bural Route Numb		-,	Code) n c	
Definitione, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 to marked	B		Dora E. Gray- 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	☐Removal from	State	1854 Place of Dispo- cemetery, cren ohn We	4 01 sition (Na natory or	ueen ime of other place,	Elizal	beth Dr Date 5/2006	Bro 20c. Loca	okevil ation - City or To rksbur	le,MD own, Slate)
Dalt. permit. Departm	SUC.	4	21. Sinature of Funeral Service Lic	ensee /	ad	22 W	Name a 2 4 6	nd Address	of Facility Si	nowden gton St	Fune Roc	ral Ho	me. P	A
Coate be executed by yearing and bhysicien and physicien and the burial transit the burial transit.	cal ner		23a. Panti. Enter the disease, or coshock, or heart faillure. List on immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, flag, teaching to minute cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Non Due to Due to c.	Smell (or as a conse	Cell L equence of): Care				c or respiratory a	rrest,		Approximate Interval Bell of the Manual Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Cons	ween
The law requires that the death certific life has been signed by the attending page 2 should be detached for use as			FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, out 1 □ Live b 4 □ Pregr 9 □ Unknown	oirth 2 ☐ Fet ant at time of	al death 3 🗍	Ectopic p Other (s _i	regnancy pecify)			230	d. Date of delive Month	_	ear
w requires that been signed be detailed.	۾		art II. Other significant conditions	contributing to di	eath but not re	sulting in the uni	derlying o	ause given	in Part I.		obacco use	contribute to the	e cause of de	
	e Comp	-	25. Was case referred to medical	li diese						1 Yes	sy med? 2 X No	death?	osy findings a npletion of car 2 No	vailable use of
g Phye er this	Certification: To B		examiner? 1 Yes 2 No 7. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of (Monton		ER/Outpatient 28b. Time of Injury	3 D D C	Other: 8c. Injury at Work?	4 Nursing H	ath Check only on lome 5 Residence 128d. Describe h	ence 6)	
To the Hospitel or Attendin within 24 hours efter death. To the Funeral Director: Aft completely filled in by the fur			3 Suicide 4 Homicide 6 Could not determined	buildir	hest of my kny	owledge death	20000000	- 4 4h - 4	date and place	28f. Location (S City or Tow	n, State)			Θ/,
To the Ho within 24 To the Fu	Medical	1	(Check only one) 2 Medical Exa 9b. Signature and title of certifier	miner; On the ba and mann	isis of examination of stated.	ation and/or inve	Stigation	License n	on, death occu	rred at the time, o	late and pla	manner as states, and due to gned (Month, L	the cause(s)	
10			Paul Bauren O. Name and address of person who Paul Barren 18	completed cause			rint)	DO66		1	Febru	0927	2000	'o
Regi	State strar	3	1. Date filed (Month, Day, Year)		egistrar's Signa		de	3 2	TU	lney, A	AD 2	-0852		

			1 - For State Registrar	State of Mai		artment of rtificate of			iene 0 06	08039
100	Physici /Medi		1. Decedent's Name (First, Middle, Last, Marion Feingo					2. Date of Deat Month Februar	Day Year	3. Time of Death 8:25 A.
16	Examir		4a. Facility Name (If not institution, give s Shady Grove Adven	· ·	tal	4b. City, Town, Rockvi	or Location of Dea		4c. County of Death	1
	Funeral Director		5. Social Security Number 6. Security Number 132-16-3119 Usual Residence of Decedent	7. Age	(In yrs. last birthday) 80 Yrs.	If Under 1 Yea Months Day			9 Birth	nplace (State or Foreign Lighty) York
	Maryland i-f ahow	tor	10a. State 10b. County Maryland Montgome		10c. City, Town or Lo					10d. Inside City Limits X☐ Yes 2 ☐ No
	th with the 23a or 28a	Funeral Director	10e. Street and Number 14 Monroe Street,	# 102		10f. Zip Code 20850		1	0g. Citizen of What Co	untry?
3030	be filed within 72 hours after death with the Maryland ital Hyglene. Id other then "natural", or items 23e or 28e-f show avent, the Medical Examinat must be notified at	by	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2X No		Specify Yes or No- irto Rican, etc.)	14. Race - Amer Black, White Specify: Wh	, etc.
751212	d within 72 h piene. r than "natu the Madical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+) 1 Year		dent's Usual Occ kind of work don DO NOT use retir nemaker	upation e during most of w ed)	orking	Own Home	ndustry
Baitimore, Maryland 21215-0036	2 should be filed and Mental Hygis te marked other reumatic avant, II	To Be C	17. Father's Name (First, Middle, Last) Morris Okrent				Yetta	ame (First, Middle, A Leventha	.1	
e, Mar	permit. Pages 1 and 2 should Department of Health and Men Importent: If Item 27 Ie marke any injury or other treumatic. anse.		19a. Informant's Name/Relationship (Ty, Harry Feingold –	,	14 Mc	nroe St	reet, # 1	02, Rockv	City or Town, State, Z.	20850
пппог	permit. Pages Department of I Importent: If its any injury or o		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License			lem. Gard	dens 3/1/	2006	Olney, Mar	y1and
Da	Departit Departit Import any inj		Sonald C. X	Stottlem	yez 11	70 Rock	ville Pik	e, Rockvi	Chapels,	
,00	Physician American and Provided American and Provided American and Provided American	at Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a o	PNEU consequence of):	120 N	IA	RT FAI		Interval Between Onset and Death 2 week
O. DOX 001	sath certificate attending phy for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □Live birth 2 4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	Ectopic pregnand Other (specify)			23d. Date of deliving Month	rery Day Year
ecolus, r	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions con	tributing to death but r	not resulting in the ur	nderlying cause g	iven in Part I.		acco use contribute to	the cause of death?
ב ב ב	The law ate has b page 2 st	Completed						24a. Was ar autopsy perform 1 Yes 2	ned? prior to co	opsy findings available ompletion of cause of
5	al d	atlon: To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 28a. Date of Injury (Month, Day Y		28c. Inju	ther: 4 🗆 Nursing	eath (Check only one Home 5 Reside 28d. Describe ho	nce 6 Other (Speci	fy)
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc. (City or Town	,	
	the Hosp thin 24 hou the Fune mpletely fi	Medical	one)	ician: To the best of r ier: On the basis of ex and manner stated	tamination and/or inv	estigation, in my	opinion, death occ	curred at the time, da	use(s) and manner as s te and place, and due t	to the cause(s)
	5 × 100		29b. Signature and title of certifier	Zur Z	ser ino	00	se number		d. Date signed (Month,	
	Sta Registr		30. Name and address of person who compared to the series of person who compared to the series of th	13219 Ex		ark Terr	ace, Ger	mantown,]	Maryland 2	20874

EUGENIA

D'AMBROSIO,

The proposed property The proper			1_ For State	State of Maryla	ind / Dep	artment of I	lealth and	-	ene	00011
Position Tended of Control Co			Registrar		Ce	rtiticate of	Death		1. No. U U O	00041
Part Control Part Part Control Part	Physic	ian							Day Year	
73.19 Righter's Mill Road Rockville Montgomery 388-56-5215 M CP 45 M C	/Medi	cal				4h Chi Taum	-1	1101	THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAM	
Social Security Numbers Security Security Numbers Column Co	Exami	ner		·						
Signature Sign	Funeral			x 7. Age (In yr	s. last birthday)	If Under 1 Year	If Under 24 Hrs			
The state of the s			338-56-5215			Months Days	Hours Min.			
Raymond Lester Owen Raymond Lester Owen Betty Jo Tuggle Ferguson 19s. Informaris Name/Relationship (Type, Print) 19s. Making Address (Steet and Number of Plusia Route Number	pu ,			10-7	31. 7					
Raymond Lester Owen Raymond Lester Owen Betty Jo Tuggle Ferguson 19s. Informaris Name/Relationship (Type, Print) 19s. Making Address (Steet and Number of Plusia Route Number	aryla shov	2	Toa. State Tob. County	106. 0	Jity, Town or Lo	ocation				
Raymond Lester Owen Raymond Lester Owen Betty Jo Tuggle Ferguson 19s. Informaris Name/Relationship (Type, Print) 19s. Making Address (Steet and Number of Plusia Route Number	he M	ectc		y Roc	<u>ckville</u>	1.04 71 0 1				11
Raymond Lester Owen Raymond Lester Owen Betty Jo Tuggle Ferguson 19s. Informaris Name/Relationship (Type, Print) 19s. Making Address (Steet and Number of Plusia Route Number	with t	ğ		1 5 1				100	. Citizen of What C	ountry?
Raymond Lester Owen Raymond Lester Owen Betty Jo Tuggle Ferguson 19s. Informaris Name/Relationship (Type, Print) 19s. Making Address (Steet and Number of Plusia Route Number	leath ns 23	era			U.S. 13		dispanic Origin? (9			
Raymond Lester Owen Raymond Lester Owen Betty Jo Tuggle Ferguson 19s. Informaris Name/Relationship (Type, Print) 19s. Making Address (Steet and Number of Plusia Route Number	ir Iter	핕	1 Never Married 2 Married	1 TYes 2 TNo	i		an, Mexican, Puer	to Rican, etc.)	Black, Whi	te, etc.
Raymond Lester Owen Raymond Lester Owen Betty Jo Tuggle Ferguson 19s. Informaris Name/Relationship (Type, Print) 19s. Making Address (Steet and Number of Plusia Route Number	rel', o	b	3 Widowed 4 Divorced	If Yes, Give	İ	1 □ Yes 2 RNo	Specify:		Specify: Wh	ite
Raymond Lester Owen Raymond Lester Owen Betty Jo Tuggle Ferguson 19s. Informaris Name/Relationship (Type, Print) 19s. Making Address (Steet and Number of Plusia Route Number	72 ho	etec	15. Decedent's Edu (Specify only highest grad	cation le completed)	(Give	kind of work done	during most of wo	rkina 16	b. Kind of Business	/Industry
Raymond Lester Owen Raymond Lester Owen Betty Jo Tuggle Ferguson 19s. Informaris Name/Relationship (Type, Print) 19s. Making Address (Steet and Number of Plusia Route Number	vithin ne. han	ם		College (1-4or 5+)	life.	DO NOT use retire	d)		eintina	
Raymond Lester Owen Raymond Lester Owen Betty Jo Tuggle Ferguson 19s. Informaris Name/Relationship (Type, Print) 19s. Making Address (Steet and Number of Plusia Route Number	filed v Hygie ther t				10100	operato				
23a Part Lens the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Causes (Final Immediate Causes on each line.) Immediate Causes (Final Immediate Causes on each line.) Immediate Causes (Final Immediate Causes on each line.)	d be intal l	Be C		en						
23a Part Lens the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Causes (Final Immediate Causes on each line.) Immediate Causes (Final Immediate Causes on each line.) Immediate Causes (Final Immediate Causes on each line.)	should nd Me mark	ř	19a, Informant's Name/Relationship (Tv	rpe. Print)	19b. Mailir	ng Address /Street				Zin Code l
23a Part Lens the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Causes (Final Immediate Causes on each line.) Immediate Causes (Final Immediate Causes on each line.) Immediate Causes (Final Immediate Causes on each line.)	nd 2 :: lith ar 27 is r treu		111							
23a Part Lens the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Causes (Final Immediate Causes on each line.) Immediate Causes (Final Immediate Causes on each line.) Immediate Causes (Final Immediate Causes on each line.)	s 1 ar				Place of Disno	sition (Name of	-			
23a Part Lens the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Causes (Final Immediate Causes on each line.) Immediate Causes (Final Immediate Causes on each line.) Immediate Causes (Final Immediate Causes on each line.)	Page in the go				tropo1	itan Crem	Mar.	1, 2006A1	exandria	, VA
23a Part Lens the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Causes (Final Immediate Causes on each line.) Immediate Causes (Final Immediate Causes on each line.) Immediate Causes (Final Immediate Causes on each line.)	partm porta				22	2. Name and Addre	1			
23a Part. Enfer the diseased or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Shock, or heart failure. List or one failure is under the mode of dying, such as cardiac or respiratory arrest. Approximate Shock or heart failure. List or one failure is under the mode of dying, such as cardiac or respiratory arrest. Approximate Shock or heart failure. List or one failure. List or one failure is under the mode of dying, such as cardiac or respiratory arrest. Approximate Shock or heart failure. List or one failure is under the mode of dying, such as cardiac or respiratory arrest. Approximate Shock or heart failure. List or one failure is under the mode of dying, such as cardiac or respiratory arrest. Approximate Shock or heart failure. List or one failure is under the mode of dying, such as cardiac or respiratory arrest. Approximate Shock or heart failure. List or one failure is under the mode of dying, such as cardiac or respiratory arrest. Approximate Shock or one failure is under the mode of dying, such as cardiac or respiratory arrest. Approximate Shock or one failure is under the mode of dying, such as cardiac or respiratory arrest. Approximate Shock or one failure is under the mode of dying. But 10 (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23d. Date of delivery mode or one failure is under the mode of delivery mode or one failure is under the mode of delivery mode or one failure. Due to (or as a consequence of): 23d. Date of delivery mode or one failure. Due to (or as a consequence of): 23d. Date of delivery mode or one failure. Due to (or as a consequence of): 23d. Date of delivery mode or one failure. Due to (or as a consequence of): 23d. Date of delivery mode or one failure. Due to (or as a consequence of): 23d. Date of delivery mode or one failure. Due to (or as a consequence of): 23d. Date of delivery mode or one failure. Due			Mas. Gr	,	Pi	ike, Rock	ville. M	mpie 11100 D 20852	1040	ROCKVIIIe
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions Sequentially list conditi			23a. Part1. Enter the disease or complishock, or heart failure. List only of	ications that caused the der						Approximate
Due to (or as a consequence of): Sequentially list conditions is a state of the constitution of the con	Pnysician		Immediate Cause (Final		Non Sm	all Cell	Lund			Onset and Death
Sequentially list conditions if any, lagging to mind alter clause (Disease or righty) and the property of the						0011	Luir			Months
The proposed of the proposed o	Cxammer	L	Sequentially list conditions,							
The post of the post 12 months? 1	ed sit	ine	if any, leading to immediate	Due to (or as a conse	equence of):					
The post of the post 12 months? 1	xecut and al-trar	xan	that initiated events	Due to (or as a conse	equence of):					
The part of the part is sometiment of the pa	be e sician buria	a E	l l							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **XXYes 2 No 3 Probably 4 Unknown 24a. Was an autopsy prior to completion of cause of death? **XXYes 2 No 3 Probably 4 Unknown 24a. Was an autopsy prior to completion of cause of death? 25c. Was case referred to medical examiner? 1 Yes 2 No 27c. Manner of Death 1 Nother significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25c. Was case referred to medical examiner? 1 Yes 2 No 27c. Manner of Death 1 Nother significant conditions contribute to the cause of death? 25c. Was case referred to medical examiner? 1 Yes 2 No 27c. Manner of Death 1 Nother significant conditions contributing to death but not resulting in the underlying cause given in Part I. 26c. Place of Death (Check only one) 27c. Manner of Death 1 Nother significant conditions contribute to the cause of death? 27c. Manner of Death 1 Nother significant conditions contributing to death but not resulting in the underlying cause given in Part I. 27d. Part of Nother significant conditions contribute to the cause of death? 27d. Was an autopsy prior to completion of cause of death? 27d. Nother significant conditions contributing to death of Nother significant conditions availage prior to completion of cause of death? 27d. Nother significant conditions contributing to death of Nother significant conditions availage prior to completion of cause of Death (Check only one) 27d. Manner of Death 27d. Manner o	ficate g physis the			l						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **XXYes 2 No 3 Probably 4 Unknown 24a. Was an autopsy prior to completion of cause of death? **XXYes 2 No 3 Probably 4 Unknown 24a. Was an autopsy prior to completion of cause of death? 25c. Was case referred to medical examiner? 1 Yes 2 No 27c. Manner of Death 1 Nother significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25c. Was case referred to medical examiner? 1 Yes 2 No 27c. Manner of Death 1 Nother significant conditions contribute to the cause of death? 25c. Was case referred to medical examiner? 1 Yes 2 No 27c. Manner of Death 1 Nother significant conditions contributing to death but not resulting in the underlying cause given in Part I. 26c. Place of Death (Check only one) 27c. Manner of Death 1 Nother significant conditions contribute to the cause of death? 27c. Manner of Death 1 Nother significant conditions contributing to death but not resulting in the underlying cause given in Part I. 27d. Part of Nother significant conditions contribute to the cause of death? 27d. Was an autopsy prior to completion of cause of death? 27d. Nother significant conditions contributing to death of Nother significant conditions availage prior to completion of cause of death? 27d. Nother significant conditions contributing to death of Nother significant conditions availage prior to completion of cause of Death (Check only one) 27d. Manner of Death 27d. Manner o	nding use a	M/U		3c. If yes, outcome of pregi					23d. Date of de	livery
Part II. Officer significant conduitions contributing to death but not resulting in the underlying cause given in Part I. 238. Did tobacco use contribute to the cause of death?	death e atte	Icla	in the past 12 months?	4 Pregnant at time of			′			,
Part II. Officer significant conduitions contributing to death but not resulting in the underlying cause given in Part I. 238. Did tobacco use contribute to the cause of death?	t the by th tache	hys		9∐ Unknown						
25. Was case referred to medical examiner? Types 2 No	es tha		Part II. Other significant conditions cor	tributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.			
25. Was case referred to medical examiner? Types 2 No	equir en si ould							¥ŒYes	2 □ No 3 □ P	obabiy 4 □Unknov
25. Was case referred to medical examiner? Types 2 No	taw ras be	ple							24b. Were at	utopsy findings availab
25. Was case referred to medical examiner? 1 Yes 2 No. 27. Manner of Death 1 Yes 2 No. 28a. Date of Injury 28b. Time of Injury 28b. T		Con						performe	d? death?	
The state of the s	cian; ertific ector,	a	examiner?							
Security at Security at	Physic this c	\vdash	1 162 5 WAO	1 Linpatient 2L		t 3 DOA Oth	er: 4 Nursing H			cify)
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)	ding I	lo	1X Natural 5 ☐ Pending	(Month, Day Year)		Wor	k?	28d. Describe how	injury occurred	
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)	death ctor: / the	icat	3 ☐ Suicide 6 ☐ Could not be	28e Place of Injury - At I	homo farm etr		Tes ZUNO	28f Location (Street	at and Number or Pi	ural Pauto Mumba
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)	lor A after Dire	ertit	4 Homicide determined	building, etc. (Spec	eify)	eet, lactory, office		City or Town, S	itate)	arar Houte Number,
29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) Petropology 29d. Date signed (Month, Day, Year) Petropology 30. Name and address of petropology 30. Name and address of petropology 31. Name and address of petropology 32. License number D42452 February 28, 2006 Chitra Rajagopal, MD; 18111 Prince Phillip	bspita hours uneral ly filled		29a. Certifier 1 Certifying Phys	sician: To the best of my kn	nowledge, death	occurred at the tin	ne, date and place	, and due to the caus	e(s) and manner as	stated.
29b. Signature and title of certifier 29c. License number D42452 Pebruary 28, 2006 30. Name and address of per who impleted cause of death (Item 23a) (Type, Print) Drive, Olney, MD # 332 20832	the H in 24 he Fi		(Check only 2 Medical Examin	ner: On the basis of examin	nation and/or inv	estigation, in my o	pinion, death occu	rred at the time, date	and place, and due	to the cause(s)
30. Name and address of perform who simpleted cause of death (Item 23a) (Type. Print) Chitra Rajagopal, MD; 18111 Prince Phillip Drive, Olney, MD # 332 20832	To the To the Comp		(11)			l l			-	*
30. Name and address of per who projected cause of death (Item 23a) (Type, Print) Chitra Rajagopal, MD; 18111 Prince Phillip Drive, Olney, MD # 332 20832	4		I Chilie again	fre						
		. 3	30. Name and address of person who	mpleted cause of death (Ite	em 23a) (Type,	Print) Chitr	a Rajago	pal, MD;	18111 Pri	nce Philli
State State State MAR 0.2. 2006 State Sta										
				32. Hegistrar's Sign	nature	early				

			1 - State Registrar		ryland / Dep Ce	ertificate of			Reg. No.		U0U42
	hysici /Medic		Decedenl's Name (First, Middle, Las RUTH HARROLD	BARROW				2. Date of Do Month Februa	Day	2 ^{Year} 2006	3. Time of Death
	xamin		4a. Facility Name (If not institution, give Holy Cross Hospi	·		· ·	r Location of Death Spring		4c. Coun	y of Death	ry
	neral ector		5. Social Security Number 6. Sec 180–20–2066	ox 7. Age □M 2XTF	(In yrs. last birthday 80 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di May 12	rth ay, Year) ,1925	9. Birthp Cour PA	olace (State or Foreig ntry)
Maryland	find at	tor	Usual Residence of Decedent 10a. State 10b. County Md. Montgom	ery	10c. City, Town or t Rockvil					1	10d. Inside City Limits
with the	Libernoti	Direc	10e. Street and Number 5406 Parkvale Ter	race		10f. Zip Code	53-2532		10g. Citizen of		•
5-0036 72 hours after death with the Maryland	o other man institute, or tame 25s of 28e-1 anow event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🔯 N If Yes, Give Year or Dates:	ver in U.S. 13	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No		Decify Yes or No Rican, etc.)	o- 14. Ra	ice - Americ ack, White,	can Indian,
11215-00 within 72 ho	Medical E	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4or 5-	(Giv	edent's Usual Occup e kind of work done DO NOT use retired	ation during most of work d)	king	16b. Kind of B		dustry
Maryland 21215-0036 Id 2 should be filed within 72 hours aff thit and Menial Hygiene.		To Be Col	12 17. Father's Name (First, Middle, Last) Franklin M. Harr	old	Ban	k Teller	18. Mother's Nam	e (First, Middle			
re, Maryle 1 and 2 should Health and Mer	ar traumatic av	-	19a. Informant's Name/Relationship (7) Billy A. Barrow	ype, Print) (Husband)		ing Address (Street					,
Baltimore, permit. Pages 1 and Depentment of Heal	١٥٥		20a. Method of Disposition 1 Description 1 Description 1 Description 2 Description 2 Description 3 Description 3 Description 4 Description 5)	Harrold Church C	matory or other plac Zion Luth emetery	eran Marc 200		20c. Location		
Balt Permit. Depertin	eny injury		21. Signature of Funeral Service Licens	See Comments		22. Name and Address O East De	De		neral Ho thersbur		. 20877
	ician dical niner		234. Part1. Enler the disease, or complete shock, or healt failure. List only of limediate Cause (final disease or condition resulting in death) Sequentially list conditions	a. Sepsis	the death. Do not er e. consequence of):	nter the mode of dyin	ig, such as cardiac	or respiratory a	trrest,		Approximate Interval Between Onset and Death
68760, ifficate be executed	the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Entire Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	consequence of):						
BOX 6	n ed	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₺ No 9 □ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)	,			ate of deliver	ery Day Year
ords, P	De d	þ	Part II. Other significant conditions co Conjestive Heart		t not resulting in the	underlying cause give	en in Part I.		tobacco use con Yes 2∰No		he cause of death? pably 4 DUnknown
The lawre	page 2 shoul	Completed	Acute Gastritis Urinary Tract In	fection				24a. Was auto perfe		Were auto prior to con death? 1 \(\text{Yes} \)	psy findings available mpletion of cause of 2 No
o £ f	funeral director,	ion; To Be	27. Manner of Death 1X Natural 5 □ Pending	Hospital: 1 🔀 Inpalien 28a. Date of Injury (Month, Day	t 2 ER/Outpatie	of 28c. Injun World	/ al k?	ome 5□Resi			y)
DIVISION To the Hospital or Attending within 24 hours after death.	d in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injurbuilding, etc.	ry - Al home, farm, s (Specify)		Yes 2 □ No	28f. Location (City or To	Street and Num wn, State)	ber or Rura	I Route Number,
na Hospital n 24 hours a	oletely fills	ledicai C	29a. Certifier (Check only one) 1 Certifying Phy one) 2 Medical Exami	rsician: To the best of iner: On the basis of e and manner slate	examination and/or it	th occurred at the time nvestigation, in my of	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and m date and place,	anner as st and due to	tated. the cause(s)
To the	- 1	Me	29b. Signature and tille of certifier 30. Name and address of person oc	Completed cause of de	MA	29c. License 263			29d. Date signe Februa		Day, Year) 7, 2006
			Dr. Ira Ruban M.D	. 1500 F	orest Gle	n Road, S	ilver Spr	ing, Mo	1. 20910	-1484	i .
R	Sta egistr		31. Date filed (Month, Day, Year) MAR 0 2 2	32. 3 9istrar	's Signature	book					

			1 = For State Registrar	State of Ma	ryland /	Depa Cer	artmen tificat	t of H e <i>of L</i>	ealth a	and N		giene Rag. No.	006	08043
			1. Decedent's Name (First, Middle, Last,								2. Date of Dea	ıth		3. Time of Death
Н	Physic /Medi		Anthony Oxcequ	iel Cha	vez						Februar	y 23.	2006	2:44 p ^M
>	Exami		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location of	of Death			unty of Deat	
			Holy Cross Hospit	a1			Si	lver	Spri	ng		Me	ontgon	nery
	Funeral		Social Security Number 6. Security Number	7. Age	(In yrs. last		If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birth (Month, Day	1		hplace (State or Foreign untry)
	Director		None	M 2UF	() Yrs.	0	2	Tiodis	IVIII I.	02/21/2			yland
	and *		Usuel Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation							10d Inside Oit Limite
	Aaryl I eho	5	Maryland Montgon											10d. Inside City Limits 1 X Yes 2 No
	28a-	Director	Maryland Montgon	iery	Gal	ners	burg 10f. Zip	Codo				10- 02:		
	with a or	ā	329 E. Diamond A	#204				0877					of What Co	untry?
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or Iteme 23a or 28a-f ehow aumatic event, I're Medical Examinar must be notified at	Funeral		12. Was Decedent Ev	ver in U.S.	13 \			enanic Orig	ain2 /Sn	acifu Vac or No	USA	Race - Amer	door ladie
10	fler d	핊	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		15. 1	Yes, spec				ecify Yes or No- Rican, etc.)		Black, White	
ဗ္ဗ	ol', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	X Yes 2	⊇□ No	Specify:	1 Sa	1vador	Spe	ecity:	r Caucasiar
Maryland 21215-0036	2 ho	Completed	15. Decedent's Edu	cation	16	a. Deced	ent's Usua	i Occupa	TION			16b. Kind o	of Business/I	
2	nin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		(Give I life. [kind of wor OO NOT us	k done d e retired)	uring most	t of work	ing			,
2	d wit	Š	0	CONGGO (1-401 34)		Non	e					None	2	
g	othy A	a u	17. Father's Name (First, Middle, Last)	A.					18. Mothe	r's Name	(First, Middle,			
<u>a</u>	Went Went with w	2	Jose M. Chavez						Mar	tha	L. Chave	ez		
an	and l	ľ	19a. Informant's Name/Relationship (Ty)	pe, Print)	15	9b. Mailin	g Address	(Street a			al Route Number		wn, State, Z	ip Code)
Σ	and 2 palith n 27		Jose M. Chavez /	Father	3	29 E	. Dia	mond	l Ave	. #2	04; Gai	therst	our.	MD 20877
Baltimore,	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		20a. Method of Disposition		20b. Place	of Dispos	sition (Nam	a of					on - City or T	
Ĕ	Page History		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State						3/01	/2006	Germ	nantow	n MD
a	permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked only injury or other traumatic av once.		21. Signature of Funeral Service License	18							ral and			
m	89 E ≥ 8		Mass. Ch			10	mp⊥e 40 Ro	Trib	ute 1	Fune Pike	ral and ; Rockvi	Crema 111	ation of	Center 852
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the	ne death. Do	not ente	r the mode	of dying	, such as	cardiac o	or respiratory arr	est,	TID 20	Approximate
	Physician		Immediate Cause (Final disease or condition	Right Dia		mati	о Пом	nia						Interval Between Onset and Death
•	/Medical		resulting in death)	Due to (or as a			c ner	пла						2 days
Н	Examiner			Multiple			1 Ano	mali	25					2 days
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	e of):	- 1110	MOTI						2 days
	cuted od ransii	Examiner	that initiated events	Fryns Syr	ndrome									2 days
o,	en ar	EX	resulting in death) Last	Due to (or as a	consequence	e of):								
09/g	death certificate be executed e ettending physicien and id for use as the burial-transit	dical	L.											
٥	ntifica ng ph as th	Med	IS SERVICE											
X O D	eath certific ettending p	Physician/Me	200. YVas decedent pregnant	Bc. If yes, outcome of 1 ☐ Live birth 2	pregnancy	h 2∏ı	Ectopic pre					23d.	Date of deliv	rery
	ed fo	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at tin			Other (spe						Month	Day Year
	that the de ned by the e detached	چ	9 Unknown											
ທົ	w requires that s been signed b should be deta	by	Part II. Other significant conditions con	tributing to death but	not resulting	in the un	derlying ca	use giver	in Part I.		23e. Did tob	acco use c	ontribute to 1	the cause of death?
ecoras,	equir en si ould	ed									1 □ Ye	s 2 No	3 Pro	bably 4 Unknown
ပ္	as b	Completed									24a. Was a		b. Were auto	opsy findings available
r	The ste ha	E								_	autops perform 1 Yes 2	ned?	prior to co death? 1 \(\sum \text{Yes}	ompletion of cause of
VITAL	ding Physician: The law h. Affer this certificete has t funeral director, page 2 s	Bec	25. Was case referred to medical			_			26. Place	of Death	(Check only one		1 1 105	2□ No
<u> </u>	Physician: r this certific ral director.	2	examiner? 1 ☐ Yes 2 ☒ No	ospital: 1 🖾 Inpatient	2 🗆 ER/O	utpatient	3 DO/				ne 5 Reside		Other (Specia	fv)
0	ng Pt		27. Manner of Death 1 ⊠ Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	28b.	Time of Injury	28	c. Injury a	at	- 2	28d. Describe ho	w injury occ	curred	
Vision	endii path. pr: A	atte	2 ☐ Accident investigation	(,	,,	М		es 2□N	lo				
<u> </u>	recte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (- At home, f	arm, stre	et, factory,	office		2	28f. Location (Sti City or Town	reet and Nu	mber or Rur	al Route Number,
ב	rs eff	Č		banding, etc. (Opecity)						City of Town	, State)		
8	To the Hospital or Attending P within 24 hours elter death. To the Funerel Director: After it completely filled in by the funera	Medical	29a. Certifier (Check only one) 1 ☑ Certifying Physical Continuous (Check only one)	cian: To the best of re: On the basis of exand manner state	amination a	ge, death nd/or inve	occurred a estigation, i	t the time n my opir	, date and nion, death	place, a	and due to the ca	use(s) and ite and plac	manner as s e, and due t	stated. o the cause(s)
	Withir To th	M	29b. Signature and title of certifier				29c.	License	number		29	d. Date sig	ned (Month,	Day, Year)
			- CA	2		1	T	アン	~ ~ ~	•				
		-	30. Name and address of person who cor	onleted cause of day	h /lto= 22=1	/Tues 0	riot\	22	500	<u> </u>		02-23	-2006	
			Janel Kelly Hino,					Dag	1. 64	1,770	Spring	М	1	20010
	Sta	e	31. Date filed (Month, Day, Year)	3 Registrar's	Signature	Less L	# B	KOd	1, 51	iver	spring	, Mar	yıand	20910
	Registra		MAR 0 2 200		A.S.	A STATE OF								

1			1 - For State Registrar	State of Marylan	d / Depa		t of He	ealth an	d Mental Hy		006	030	The state of the s
4.	Physic		1. Decedent's Name (First, Middle, Last) James Willis Bu	rdette, Sr.					2. Date of D Month Febru		27, Year 200	3. Time	of Death
	/Medi Examir		4a. Facility Name (If not institution, give : Montgomery Gener	•			Town, or t	ocation of D	eath		County of Deat	1	
	Funeral Director		220-26-6943	7. Age (In yrs.	last birthday) 83 ^{Yrs.}	If Under Months	1 Year Days	If Under 24 Hours N	Hrs. 8. Date of Bi Min. (Month, D June 6,	rth ay, Year) 192	9. Birti Co Mar	nplace (State untry) yland	or Foreign
	Maryland	tor	Usual Residence of Decedent		y, Town or Lo							10d. Inside	City Limits
	with the ta or 28s	Direc	10e. Street and Number 3303 Janet Road			10f. Zip	Code 2090	n6		10g. Citiz	zen of What Co USA	untry?	
36	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "naturel", or items 23a or 28s-1 show event, I've Medical Evan are must be notified at	by Funeral Director		12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 图题 o If Yes, Give Year or Dates:		Vas Deced f Yes, spec	ent of His Ify Cuban	panic Origin' , Mexican, P	? (Specify Yes or Nuerto Rican, etc.)		4. Race - Ame Black, White Specify:Whi	etc.	
Maryland 21215-0036	within 72 hou ene. than "nature he Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12		16a. Deced (Give life. L	kind of wor OO NOT us	l Occupat k done du e retired)	ion iring most of	working	Mont	nd of Business/i	Count	У
yland 2	should be filed within nd Mental Hygiene. marked other than '	To Be Co	17. Father's Name (First, Middle, Last) Amos D. Burdette		Dilgi	neer	1		Name (First, Middle	, Maiden S		3015	
	and 2 sho alth and 127 ie m er traum	4	19a. Informant's Name/Relationship (Ty) Violet Ann Burdet						r Rural Route Numb eaton, Ma				
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important; If lew 27 is marked ery injury or other traumatic engine.		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	eliloval liolil State	lace of Disposemetery, crem Klawn Me				ch 2,		cation - City or		and
Balt	permit, Departr Imports eny inju		21. Signature of Funeral Service License	98	F: 50	ranci 00 Un	Address ivers	Colli	ns Funera lvd, W, S	1 Hon	ne Inc		
	Physician and physician and physician and physician and physician site physician and p	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)	1 Carc:					rrest,		Approxima Interval Be Onset and	etween
O. Box 68760,	t the death certiff by the attending ached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1	death 3 🗌	Ectopic pre Other (spe				2:	3d. Date of deliving Month	very Day	Year
rds, P	w requires that been signed I should be det	by	Part II. Other significant conditions con	tributing to death but not resu	ulting in the un	derlying ca	use given	in Part I.		tobacco us Yes 2 □	se contribute to No 31∑Pro	the cause of bably 4	
al Records,		Completed							24a. Was auto perfe 1 Yes	psy ormed?	24b. Were aut prior to c death? 1 \(\subseteq Yes	ompletion of	s available cause of
sion of Vital	Attending Physician: The laving death. ector: After this certificate has by the funeral director, page 2	ation; To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 patient 2 2 28a. D te of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury		Other: Ic. Injury a Work?	4 □ Nursin	Death Check only g Home 5 Resi 28d. Describe	idence 6		rfy)	
Division		Certification	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory,	office			Street and wn, State)	Number or Rui	al Route Nur	nber,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one) (Check only one)	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred a estigation,	t the time in my opir	, date and plantion, death o	ace, and due to the courred at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause((s)
	To the To the Comple	Me	29b. Signature and title of bertfier	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	212	29c.	License r				signed (Month		6
	>		30. Name and address of person who con Joseph Kaplan, M.I				Olney	, MD :	20832				
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 2 200	32 Registrar's Signat	ure die	ill							

DHMH 17 Rev 1/2001

State

Registrar

ARTIS PATINE, EYVETTE, 3/13/06 16:48

Rockville, MD 20852

M.D. 121 Congressional Lane # 409

3 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. Rajvansim,

MAR 1 6 2006

31. Date filed (Month, Day, Year)

			1 - For Stata Registrar	State of Marylan		artment of F			giene Reg. No.	UUU	08046
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Michael	R.		Blimme		2. Date of De Month	15 ^{Da}	12001	(1)
	Examin	er	4a. Facility Name (If not institution, give s BO TO TO TO TO TO TO TO TO TO TO TO TO TO	ngton Midsen	(en)	4b. City, Town, o	r Location of	writ	19	County of Dea	grundel
	Funeral Director		216-74-4098 Usual Residence of Decedent	M 2□F 47	Yrs.	Months Days	Hours	Apr. 4	v. Year)	58 Per	thplace (State or Foreign ountry) nnsylvania
	he Marylar Ba-f show	ector	10a. State 10b. County Maryland Anne Art		y, Town or Lo adena						10d. Inside City Limits 1 ☐ Yes 2 No
	h with t	al Dir	1770 Wye Drive			10f. Zip Code 2112	22		10g. Citi	U.S.A.	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Items 23a or 28a-f show appring yor other traumatic avant. I'm Medical Exam and matter notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	'	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Originan, Mexican, I Specify:	n? (Specify Yes or No Puerto Rican, etc.)	-	14. Race - Ame Black, Whit Specify:	
21215-0036	filed within 72 ho Hygiene. khar than "natur ant, 11: Wedical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most o	of working	Anne	ind of Business Arunde Lic Scho	el County
nd 2	al Hygi al othar vant.	Be	17. Father's Name (First, Middle, Last)	11, 21			18. Mother's	s Name (First, Middle			0012
ryla	should be nd Mental markad c	Tol	James 19a. Informant's Name/Relationship (Type)	ne Print)	Blimme		Barba	ra or Rural Route Numb	er City o	r Town State	Irwin
, Ma	and 2 s salth an n 27 is ter trau		Laura A. Blimmel	(Wife)	1770	O Wye Dri	ve Pas	sadena, Mai			
nore	Pages 1 nent of He int: if Itar iry or oth		20a. Method of Disposition 1 Burial 2 Scremation 3 B.	emoval nom State		sition (Name of matory or other place		Date 100		ocation - City or	
Baltimore, Maryland	permit. Page Department of Important: if any injury of		'4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Service License			Crematory		3/20/06 Funeral H Dad Pasader	lome,	nore r	Maryland
	7		23a. Part1 Enter the disease, or complishook, or heart failure. List only on	cations that caused the death						daryland	Approximate Interval Between
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseq	√ 85. uefice of):	5	1 0				Onset and Death
	Examiner	er	Sequentially list conditions, Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ianca of):	KKCTS		ancer			
8760,	icate be execute physician and s the burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of);						0
Box 6	death certific e attending p d for use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3	Ectopic pregnancy	,	-		23d. Date of del Month	ivery Day Year
ds, P.O	gned be de	by	9 □ Unknown Part II. Other significant conditions con	9□ Unknown tributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did t		_1	the cause of death?
Vital Record		Completed						24a. Was auto perfo 1 □ Yes		24b. Were au prior to death?	utopsy findings available completion of cause of
	certific rector,	o Be	25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	ospital:	ER/Outpatien	it 3□ DOA Oth	Ar.	f Death (Check only only only only only only only only		C Other (See	aif d
sion of	Jing After fune	\vdash	27. Manner of Death 1 ★ Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Wor	y at	28d. Describe			спуу
Division	ital or Attanders after deathral Diractor:	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (City or To			ural Route Number,
	To tha Hospital or within 24 hours afte To tha Funaral Dir. completely filled in I	Medical	29a. Certifier f Cartifying Phys (Check only one)	ician: To the best of my kno par: On the basis of examinat and manner stated.	wledge, death tion and/or inv	n occurred at the tin vestigation, in my o	ne, date and pinion, death	place, and due to the occurred at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
)	To that within 2 To that complete	M	29b. Signature and title of certifler	mD		DH & C	e number	C	29d. Dat	e signed (Mont)	h, Day, Year)
	8		KUFI BUNI	mpleted cause of death (Item	H	Print) to	10	r. 1 65/2	n	Som ni	4, m)
2	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 6 20	32. Registrar's Signa	S. A.	Section 1					

Michael Blimme

State of Maryland / Department of Health and Mental Hygiene 16 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Howard Hardy Bradley 15, 11:08 AM March 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Greater Baltimore Medical Center Towson Baltimore TOWSOII

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, Year)

Feb. 25, 1922 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Director 219-12-3687 84 Georgia Usuel Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits or than "netural", or iteme 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes XXNo Baltimore Owings Mills Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 Pleasant Hill Lane 21117 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

X ⊠ Yes 2 □ No
If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married XXMarried Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Law Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Police Officer permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygies Important: If Item 27 is marked other th any injury or other traumatic event, the Enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin Franklin Bradley Richard Mary Hardy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Bradley / Wife Pleasant Hill Lane; Owings Mills, MD 21117 timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 3/16/06 Baltimore, MD 21. Signature Fundal Service Licensee 22. Name and Address of FacilitEckhardt Funeral chapel P.A. hehr 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2day 5 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Chisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the attending physicien and the for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 8 his certificate has been si I director, page 2 should t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check only one 25 No 1 Incatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 🗌 Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Salatural 5 ☐ Pending death, investigation 1 ☐ Yes 2 ☐ No 2 Accident the Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide To the Hospital o within 24 hours af To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO 30. Name and addr ss of person who completed cause of death (Item 23a) (Type, Print) ,ans 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 6 2006 Registrar

			1 _ Stete	State of Maryland	d / Depa		t of H	ealth a		ental Hygie	ne 200		0.901.9
			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	uncate	e OI L	Jealii	2		Np.U	6	3. Time of Death
п	Physici		Hattie Br	26.242						2. Date of Death Months Ch	Day 12	Year O6	9:20 AM
>	/Medic Examin		4a. Facility Name (If not institution, give str			4b. City,	Town, or	Location of	f Death		4c. County		J
		•	6401 Willo	w Way		C	lin.	ton.			Prince	Geor	rge's
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	• • • • • • • • • • • • • • • • • • • •	If Under Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day, Y	ear)	9. Birthpi Coun	lace (State or Foreign try)
	Director		238-88-4283	1 2XF 55	Yrs.					Jan. 12.	1951 N	orth	Carolina
	yland now		10a. State 10b. County	10c. City	, Town or Lo							10	0d. Inside City Limits
	e Mar	ctor	Maryland Prince Geo	rge's		Clint	on						1 ☐ Yes 2 Ñ No
	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or Items 23a or 28a-1 show event, the Modical Examinar must be multified at	Director	10e. Street and Number 6401 Willow Way			10f. Zip 20	Code 735			10g	Citizen of W U.S	hat Coun . A .	itry?
	ms 23	Funeral	11. Marital Status 12	. Was Decedent Ever in U.S	S. 13.	Was Deced	ent of His	spanic Orig	in? (Speci	ify Yes or No- ican, etc.)	14. Race	- Americ	an Indian,
9	or Ite	T.	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		1Yes,spec 1∐Yes 2		n, Mexican, Specify:	Puerto Ri	ican, etc.)			etc.African
003	ural',	d b	3 Widowed 4 Divorced	Year or Dates:							Specify:	Δ1.	merican
15-	n 72 in 72 in at	Completed by	15. Decedent's Educa (Specify only highest grade of	completed)	16a. Deced (Give	ient's Usua <i>kind of wor</i> DO NOT us	l Occupa k done d e retired	ition u <i>ring m</i> ost	of working	7 16	b. Kind of Bu	siness/Inc	dustry
212	filed withi Hygiene. other than	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Progr					1	pt. of	Trai	nsportation
pu	be filed Ital Hygid Id other	BeC	17. Father's Name (First, Middle, Last)	,		,		18. Mother	's Name (First, Middle, Ma	iden Sumame)	
Maryland 21215-0036	should be ind Mental markad c	2	Irvin Bennett Hon							pruill			7
Ma	2 2 2 2		19a. Informant's Name/Relationship (Type Larry Brown (Husba	·		_				Route Number, C n, Maryl			Code)
d)	s 1 and 2 if Health item 27 I		20a. Method of Disposition	20b. Pi	lace of Dispo	sition (Nam	ne of	1/4		18.2006 ²⁰			wn, State
e E	Page nent o nut; If		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer 1 ☐ Donation 5 ☐ Other (Specify)	noval from State Pati	uxent	Un. M	eth				ntingt	own,	Maryland
Baltimore,	permit. Pages 1 Department of H Important; If ite any injury or ot once.		21. Signature of Funeral Service Licensee	/	22	. Name and	d Addres	s of Facility	Lee I	Funeral	Home.	Inc.	
_	89 E 29	(1)	Trais F. Sout	m00257	6	633 0	ld A	lexan	dria	Ferry R	oad Cl	into	n, MD20735
N			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death cause on each line.	. Do not ent	er the mode	of dying	, such as c	cardiac or i	respiratory arrest			Approximate Interval Between Onset and Death
	Pnysician /Medical	ř (i	Immediate Cause (Final disease or condition resulting in death)	Tympho									I year
	Examiner		1	Due th (or as a consequ	ience of):								3
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ience of):								
1	acuted ind transii	Examiner	that initiated events c. resulting in death) Last										
60,	te be executed ysician and ie burial-transit	cal Ex	resulting in death) Last	Due to (or as a consequ	ience of);								
68760,	5 × 6		d										
Вох	death certifical e attending phy id for use as th	In/M	230. was decedent pregnant	. If yes, outcome of preg <i>nai</i> 1 ☐ Live birth 2 ☐ Fetal		Cotonio ne					23d. Date	of delive	ry
	0 0 0	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of de		Ectopic pre Other (spe					Mon	th	Day Year
P.0	that the de ed by the detached	Phy	9 Inknown Part II. Other significant conditions contri	huting to death but not resu	ulting in the u	aderlyina co	urea anve	n in Part I		23a Did tohar	co usa contri	hute to th	e cause of death?
rds,	Se Gu	d by		and to double but not resu	mung ar trio di	_	iuse giva			V.	_		ably 4 □Unknown
Record	aw require s been si 2 should t	plete								24a. Was an	24b. W	ere autor	psy findings available
l Re		Completed		,						autopsy performe 1 Yes 2 €	d? d	for to con eath? □ Yes	npletion of cause of 2 Mo
Vital	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?	2.1			100		of Death (Check only one)			
of/	ys di S	은	1 Yes 2 No	pital: 1 Inpatient 2 E			-	4 🖂 [40]	-	e 5 Aesidend			/)
	ding Ph h. After th funeral	tion	1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M	3c. Injury Work 1 □ Y	at ? ′es 2 ∐ N		d. Describe how	injury occurre	на	
Division	or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho	me, farm, str		-			f. Location (Street		r or Rura	l Route Number.
٥	ital or Att irs after d ral Direct			building, etc. (Specify						City or Town, S			
	To the Hospital c within 24 hours af To the Funeral D completely filled in	edical	29a. Certifier 1 Pertifying Physic (Check only one) 2 Medical Examine	ian: To the best of my known: On the basis of examination and manner stated.	wledge, death ion and/or inv	occurred a restigation,	at the time in my op	e, date and inion, death	l place, an n occurred	d due to the caus I at the time, date	e(s) and mar and place, a	iner as st nd due to	ated. the cause(s)
	To the To the comp	Ž	29b. Signature and title of certifier			29c.	License				Date signed		
,			Man W.	Jhun	mia	1 /		>44			acch	14	12006
	10		30. Name and address of person who com	-linn c	000	Print)	ال	fe	5+.	Balt	cmore	3	CUNY
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 6 200	32. Progistrar's Signat	ure	outh)	•						

			1 - For State Registrar	State of	Marylan		artment			and M	ental Hyg	iene	06	08049
			1. Decedent's Name (First, Middle,	Last)							2. Date of Dear Month		Year	3. Time of Death
	Physici /Medic		Mary Fitzmauric	e Boyle							3-12-2		Teal	10:45 P ^M
	Examin		4a. Facility Name (If not institution,	-	nber)				Location o				ounty of Death	
_			709 Maiden Choi		7 Ago //o.um	look hinth days	Ca1		ville Under:		B. Data of Birth		ltimor	
	Funeral Director		5. Social Security Number 205–10–5126	1□M 2 F	7. Age (In yrs 88	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day 6-13-1	9 I 7	9. Birth Cou	place (State or Foreign intry) PA
			Usual Residence of Decedent											
	nylan ihow		MD 10b. County Balti	more	10c. City	y, Town or Lo	cation atons	7111	۵					10d. Inside City Limits 1 ☐ Yes 2 No
	8a-f	octo												
	death with the Maryland tme 23e or 28e-f show if must be notified at	Funeral Director	10e. Street and Number 709 Maiden Cho	vice Lane			10f. Zip	Code 212	28		1	0g. Citize	n of What Cou USA	intry?
	leath	erai	11. Marital Status		dent Ever in U.	.S. 13.	Was Deced			gin? (Spe	ecify Yes or No-	14.	Race - Amer	can Indian,
0	or Iter	Fun	X XNever Married 2 ☐ Marrie	Armed For	rces? 2 📉 No		fYes, spec 1 □ Yes 2				ecify Yes or No- Rican, etc.)		Black, White	
o-0030	rel', c	d by	3 Widowed 4 Divorced	If Yes, Giv Year or Da	e ates:		1 Yes 2	NO NO	Specify:			Sı	pecify: W11.	
ņ	"natu	Completed	15. Decedent (Specify only highest			16a. Dece (Give	dent's Usua kind of wor DO NOT us	l Occupa k done d	ation <i>Juring</i> mosi	t of worki	ng	16b. Kind	of Business/li	ndustry
717	withir ene. then	dwo	Elementary/Secondary (0-12)	College (1	-4or 5+)		acher	6 / 6ti/ 6U,	/			Ed	lucatio	n
<u> </u>	Hygi other	0	17. Father's Name (First, Middle, L			10.	acher		18. Mothe	r's Name	(First, Middle,			11
yland	hental Mental rked	To B	Frank E. Boyl	.e						F	rances :	M. 0'	Hora	
Mary	and A le ma	1	19a. Informant's Name/Relationsh	ip (Type, Print)		1					I Route Number			
e, G	and and man an		Mrs. Betty McCul	lough/fr		A DESCRIPTION OF THE PARTY OF T		_	reek		Steven			
<u> </u>	it of H		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □Removal from	State C	Place of Disponentery, cres	natory or ot	her plac					tion - City or T	
Бащтог	it. Pa rtmen rtant: njury		4 Donation 5 Other (Sp 21. Signature of Funera Service L		St (Cather			-				ow, PA	
g	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Merital Hygiene. Department of Health and Merital Hygiene. Introduce important: If titem 27 ie marked other then "natural", or iteme 28a or 28a-f show important if titem 27 ie marked other then "natural", or iteme 28a or 28a-f show in propriet in a most the inclined at once.		21. Signatur of Funeral Service	Tule	M01364	1	Seco:	nd A	ve SW	Sin Gle	gleton n Burni	Funer e MD	al Hom 21061	e P.A.
			23a. Part1. Enter the disease, or a shock, or heart failure. List of	complications that can be one	aused the deat ach line.	h. Do not ent	er the mode	e of dying	g, such as	cardiac	or respiratory are	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a		100	rete	>						Crisel and Death
	/Medical Examiner		resulting in deality	Due to (or as a conseq	uence of):								
	3 1 13	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as a conseq	uence of):							_	
	uted d ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events											
Ď	be executed icien and burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):								
2/PU	eath certificate be executed ettending physicien and for use as the bunal-transit	lical	1	d										
٥ ×	certificate Iding phys	/Mec	IF FEMALE:	23c. If yes, out	come of progn	anov.								
gox	death o	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 Live b	inth 2 ∐ Feta ant at time of d	il déath 3[Ectopic pro					230	d. Date of delik Month	∕ery Day Year
j.	w requires that the de been signed by the should be detached	ysi	1 ☐ Yes 2 2 No 9 ☐ Unknown	9□ Unkno			2 0 11 10 140							
ري ح	requires that the een signed by th hould be detache	by PI	Part II. Other significant condition	ns contributing to de	eath but not res	ulting in the u	nderlying ca	ause give	en in Part I		23e. Did to	bacco use	contribute to	the cause of death?
ras,	equire en sig ould b										1 🗆 Y	es 2 🗩	No 3∏ Pro	bably 4 Unknown
oco eco	a a	Completed									24a. Was a	in sv	24b. Were aut	opsy findings available ompletion of cause of
<u> </u>	ate pag	Con									perfor	med?	death?	2□ No
VITAI	Physiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Tork		of Deat	Check only or	18/		
5	Phys this aldii	<u>۲</u>	1 ☐ Yes 2 ☑ No 27. Manner of Death			ER/Outpatier			4		me 5 Resid			ufy)
	B je	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig		of Injury h, Day Year)	Injury	M	8c. Injun Worl	k? Yes 2 □		200. Describe II	Ow arquiry o	acumed	
DIVISION	death ctor: A y the f	fica	3 Suicide 6 Could n	ot be 28e. Place	of Injury - At h	ome, farm, st	reet, factory	, office					Number or Ru	ral Route Number,
5	s efte	Cert fication:	4 Homicide	DUNA	ng, etc."(Specif	ry)					City or Tow	n, State)		
	To the Hospital or Attendi within 24 hours efter death To the Funeral Director: A completely filled in by the f	Medical	(Check only one)	Physician: To the examiner: On the ba	best of my kno asis of examina ner stated.	owladge deat ation and/or in	t occurred vestigation,	at the tin in my o	ie, date ai pinion, dea	id place, ith occur	and due to the tred at the time, or	auss(s) ai late and p	nd manner as lace, and due	stated. to the cause(s)
	ro the Mithin To the	Me	29b. Signature and title of certifier	/			290	. Licens	a number			29d. Date	signed (Month	, Day, Year)
		6	· ///	~ , ~	D		Ĭ	PC	744)		Mar	ch 13	700
			30. Name and advess of person v	and a distance of the same of						/	antuns.	. 1 {	4.5	.11
			Hadra (97		Men	dr (No12	(gru	. (- alove.	14	UVIA	Jus -
	Sta Regist		31. Date filed (Month, Day, Year) MAR 1 6 20	106 32. R	egistrar's Signa	ature	Section 1							
	gist	4 5 1	MHW T O VE	OU SERVICE		0								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last 2:00, Month **Physician** /Medical give street and number) 4b. City Town, or Location of Death nte of Death. (If not institution. Examiner 4ay Facility Name en. If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 08/15/1910 Birthplace (State or Foreign Country)
 BELARUS 5. Social Security Number **Funeral** Days Hours 1□M 21 F 213-47-3552 95 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23a or 28e-f ehow 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State r than "neturel", or Items 23a or 28e-f ehow the Medical Examiner must be notified at MD HOWARD ELLICOTT CITY 1 Yes X No Funeral Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7720 CHATFIELD LANE 21043 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: Specify: WHITE δ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be AVRAM TZIRELSON IDA SHEVALOVA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VIKTOR BOMAR / SON 7720 CHATFIELD LANE - ELLICOTT CITY, MD 21043 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1) Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CONG 03/15/2006 REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 John 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-tran and Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by the Part II. Other significant conditions contributing to seath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 1 No 3 Probably 4 Unknown 1 ☐ Yes Completed been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 212 No 1 Yes or Attending Physicien: director, 25. Was case referred to medical Be 26. Place of Death (Check only one examiner' Hospital: 1 Impatient Other: 1 Tes ၉ 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Mann of Death filled in by the funeral 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: : After 5 Pending 1 ☐ Yes 2 ☐ No death. М 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

(Item 23a) (Type, Print)

			1 - For State Registrar	State of Ma	aryland		artmen tificate			and M		giene Reg. No.	006	08051
	Physici		1. Decedent's Name (First, Middle, Las Gary S. C								2. Date of Dea Month March	Day 15,	2006	3. Time of Death 11:58A M
	/Medio Examin		4a. Facility Name (If not institution, give 3024 Woodside Av	e street and number)				Town, or irkvi	Location o	f Death		4c. C	County of Death	h
意.	Funeral Director		5. Social Security Number 6. S 220-36-8061	ex XIM 2□F		ast birthday) 55 Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birt May 10	, 194	9. Birth	nplace (State or Foreign untry) nsylvania
	ryland thow		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	r 28e-f	Funeral Director	Maryland Baltimo 10e. Street and Number	re		Park	ville 10f. Zip					10g. Citize	en of What Co	1 ☐ Yes 2 ☒ No untry?
	23a o	aiD	3024 Woodside Av	enue				2123					USA	
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene. Is marked other than "natural; or Items 23s or 28e-f show aumatic event, It's Medical Examination in Indition at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Woivorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Was Deced fYes, spec 1 ☐ Yes		spanic Orion, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	1	4. Race - Ame Black, White Specify: Wh	e, etc.
Maryland 21215-0036	filed within 72 ho Hygiene. other than "natur ent, the Medical I	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation de <i>completed)</i> Coll eg e (1-4or 5	+)	16a. Deced (Give life. I	kind of wo. DO NOT us	rk done a se retired,	luring mosi)		n <i>g</i>		of Business/	·
2	filed v Hygie other t	a	17. Father's Name (First, Middle, Last)			TOLK	Truck	. Ope			(First, Middle,			dstry
rylan	should be nd Mental marked c	To B	Roy Collins 19a. Informant's Name/Relationship	Time Print!		10h Mailie	a Addross	/Stroot a			da Mill		Tour State 2	7in Code)
	nd 2 sl alth and 27 is r r traur		Karen Fryer, Sis	, ,										d 21234
ore,	es 1 a of Hea fitem r othe		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □	•	20b. Pl	ace of Dispo	sition (Nan	ne of			Date		ation - City or	
altimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic. <u>once.</u>		4 Donation 5 Other (Specification Signature of Funeral Service Licer	y)	Met	tro Cr	ema to				L6/06	Balt	imore,	Maryland
Ba	Depara Depara Impo		Thomas Greyr	~	nn	5	56 ^{mat}	ion eder	Socie	Road			Inc. Maryla	nd 21228
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused one cause on each lin	10.	Do not ent			-		or respiratory ai			Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as			Desc		510	<u>.</u> [
₂ /4	unsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	a consequ	ence of):	per	100	3.0	.4				
,097	ate be executed hysician and the burial-transit	ical Exa	resulting in death) Last	Due to (or as	a consequ	ence of):								
.O. Box 68	death certific e attending p ed for use as i	Physician/Med	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3	Ectopic pr					23	3d. Date of del Month	ivery Day Year
ds, P.	uires that the de signed by the a lid be detached f	ρ	Part II. Other significant conditions of	contributing to death be	ut not resu	Ilting in the u	nderlying c	ause give	en in Part I.					othe cause of death?
Records,	The law requires that the site has been signed by the bage 2 should be detache	Completed									24a. Was autor perio 1 \(\text{Yes} \)	rmed?	24b. Were au prior to death? 1 \(\sum \) Yes	ntopsy findings available completion of cause of
ita I	hysician: The la his certificate has I director, page 2	Bec	25. Was case referred to medical examiner?							of Deat	(Check only o			
Division of Vital	ing P	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatie 28a. Date of Injur (Month, Day		ER/Outpatier 28b. Time o Injury		8c. Injury Work	4 🗀 140		me 5 Resident Residen			cify)
Divisi		Certification:	3 Suicide 6 Could not b 4 Homicide determined	e One Diseaset Inju	ury - At ho c. <i>(Specify</i>	me, farm, str	eet, factor	y, office			28f. Location (. City or To		Number or Ru	ural Roule Number,
	Hospita 14 hours Funeral tely fille	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best on miner: On the basis of and manner sta	examinat	wledge, deat ion and/or in	h occurred vestigation	at the tim , in my or	ne, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s) a date and p	and manner as place, and due	s stated. to the cause(s)
	verhin 2 To the comple	Med	29b. Signature and title of certifier)	-	290	c. License	number			29d. Date	signed (Monta	ከ, Day, Year)
1	6)							D	4460	YC		3/	15/6	
	2/	3	30. Name and a ress of person to Michael D. Suter					Park	ville	e,MD	21234			
1	Sta Regista		31. Date filed (Month, Day, Year)	32. Registra	ar's Signat									
\$ 3	ricgist	Tan .	MAR 1 6	LUUD Allace	65.0	18 A	THE STATE OF THE S							

			For State Registrar	State of M	laryland		artment rtificate			and M	_	giene	6	08	052
	D	127	1. Decedent's Name (First, Middle	, Last)							2. Date of De Month	ath Day	Year	3. Tim	e of Death
	Physici /Medi		Mdo (egain!							March	15	, 2006		30 A M
>	Examir	ner	4a. Facility Name (If not institution						Location o			4c.	County of Dea		
* .		30.	Carroll County 5. Social Security Number		spital ge (In yrs. la		If Under		inste		8. Date of Birt	th	Carrol		te or Foreign
	Funeral Director		168-12-5627	X □M 2□F	87		Months	Days	Hours	Min.	Month, Da June 26	v. Year)	918 Per	nsv1v	te or Foreign ania
	9		Usual Residence of Decedent		1.0.00							, _			
	show	5	10a. State 10b. County			, Town or Lo									e City Limits
	the M	Director	Maryland Carro	L L	l h	<i>l</i> estmi	nster 10f. Zip	Code				10g Citi	zen of What C	⊥	
	with with Liber	0	198 Donizetti	Drive			101. Zip	211	57			rog. On	USA	ouray.	
	death ms 2;	Funeral	11. Marital Status	12. Was Deceden		S. 13.	Was Deced			gin? (Spe	cify Yes or No Rican, etc.)		14. Race - Am),
9	after or tte	Ē	1 ☐ Never Married 2 🂢 Marr	Armed Forces ied 1 XYes 2 If Yes, Give	[™] 194	2	1 ☐ Yes 2		Specify:	i, rueito	moan, etc.)		Black, Wh Specify:		
21215-0036	of within 72 hours after death with the Maryland sien. I then "natural", or items 23s.or 28s-1 show the Madical Examinat must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:	194	15						105 10		White	
7	in 72 "nat	Completed	15. Deceden (Specify only highes	t grade completed)		(Give	dent's Usua kind of wor DO NOT us	k done d	luring mos	t of worki	ng	16D. K	nd of Busines	s/industry	
212	d within jiene. r then "i	mo	Elementary/Secondary (0-12)	College (1-4or	5+)	L	aborei	r				Ste	eel Ind	lustry	
b D	be filed tal Hygir d other event,	Be C	17. Father's Name (First, Middle,	Last)					18. Mothe	er's Name	(First, Middle,	Maiden	Sumame)		
Maryland	thould be d Mental marked o matic eve	To E	Sabatino Cesar:	ini		,			E	ster	ina Pi	eri			
Jar	S C CO S		19a. Informant's Name/Relations	hip (Type, Print)			-				l Route Numbe				
a)	os 1 and 2 of Health item 27 i		Mary Cesarini,	Wife	20b. Pl	198 ace of Dispo			Driv		stminst		Maryla cation - City o		
Baltimore,			1 ☐ Burial 2 ☑ Cremation	3 □Removal from State	e ce	emetery, crei	natory or ot	ther place					-		
臣	permit. Pa Departmer Importent any injury	,	 4 □ Donation ²5 □ Other (S 21. Signature of Funeral Service 		ne	tro C							imore,	Mary.	Land
Ba	Depa Impo any ir		21. Signature of Funeral Service Thomas Gregory	J. Say			Jremat 799 Ha	tion cede	Soci rick	ety Road	Of Mary Baltin	/Lanc	i, Inc.	and 21	228
	0 (11)		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	ed the death								Haryi	Approxi	
G.	Physician		Immediate Cause (Final disease or condition	D	umo	216									nd Death
	/Medical		resulting in death)	a Due to (or a			1	Q.C						0	45
	Examiner	L	Sequentially list conditions,	D	carda		ntar	100	1					Lay	<u> </u>
	ed isi	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	2	s a consequ	ience of):								400	16
	xecul and al-trar	xan	that initiated events resulting in death) Last	c. Due to (or a	s a consequ	ience of):								100	//
8760,	ate be executed hysician and the burial-transit	cal		d											
	tificate ng phys as the	ed													
Вох	death certifica e attending ph d for use as th	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic pre	egnancy				4	23d. Date of de	-	Wass
		SICI	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	at time of de	ath 5	Other (spe	ecify)					Month	Day	Year
P.0	a 2 =		Part II. Other significant condition	ons contributing to death	but not resu	ilting in the u	nderlying ca	ause dive	n in Part I		23e. Did to	obacco u	se contribute	to the cause	of death?
Records,	signed by det	d b	Tarris ones significant contains	on the dominating to doubt	Dat Hot Tool	many in the d	naonying oc	acco give	77 H7 F CATC 1.		101			robably 4	
Sor	w requir been si should	Completed									24a. Was	an	24h. Were a	utonsy findir	ngs available
œ .	e i e	duc									autop	rmed?	prior to death?	completion	of cause of
_ '	icien: Th certificate ector, pag	a	25. Was case referred to medical						26. Place	of Death	(Check only o	2 34 0 ne)	1 ☐ Ye	S 2 140	
<u> </u>	S	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Anpat	ient 2 🗆 E	ER/Outpatier	nt 3 DO	A Othe	n min		ne 5 Resid		3 □Other (Sp	ecify)	
			27. Manner of Death 1 ▲ Natural 5 □ Pendin	28a. Date of Inj (Month, D	ury ay Year)	28b. Time o Injury	28	Bc. Injury Work	at ?	2	28d. Describe I	now injur	y occurred		
sio	Attending r death. Sector: After y the fune	cati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could i	gation			М		/es 2□		20(1 1 1	D44	d \$4		
É	i die	Certification:	4 Homicide	ined 288. Place of Ir	atc. (Specify	me, farm, sti	eet, factory	, office		4	28f. Location (3 City or Tox			turai Houte r	vumber,
0	To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical Co	29a. Certifier 1 Certifyin	g Physician: To the bes Examiner: On the basis	t of my knov	wledge, deat	n occurred a	at the tim	e, date an	d place, a	and due to the	cause(s)	and manner a	is stated.	20(2)
K	the H hin 24 the 5 mplete	Medi	one)	and manner s	tated.										
	Cor Cor	-	29b. Signature and title of certifie	111	4.4	\circ	290.	0	number	-0		290. Dat	e signed (Mor	nn, Day, Yea	ir)
*			WHE	400	AVI	220) (T	Deiter	VS	205	81	57		11/	6	
			30. Name and address of person	wyo completed cause of	CL	23a) (Type,	Print)	. 5.	+31	27	West	27.7	ster 1	40 7	1157
	Sta	ate	31. Date filed (Month, Day, Year)	32 Regis	trar's Signa		ales I						10		
	Regist		MAR 1 6	2006	Car D	A STATE OF THE PARTY OF THE PAR									

			1 - For State Registrar	State of Ma	ryland / De		nt of H	ealth a		ntal Hyg	iene	6	08053
			1. Decedent's Name (First, Middle, Las	it)						Date of Dea Month		Year	3. Time of Death
	Physici /Medic		William A. Combe	2					1	March	9, ^{Day} 2006)	10:29 AMM
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City	, Town, or	Location of	Death		4c. County	of Deat	h
			Montgomery Gene	eral Hospi	tal	0.	Lney				Montg	ome	сy
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birth	Months	r 1 Year Days	If Under 2 Hours	Min. 8.	Date of Birth (Month, Day)	Year)	9. Birt	hplace (State or Foreign ountry)
	Director		330-03-1907	W. 201	90 Yr	S.			A	ug 1,	1915		inois
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits
	Aaryl.	ō	MD Montgom	erv	Silve	r Spri	nσ						1 ☐ Yes 2 ☑ No
	28a-	rect	10e. Street and Number				p Code			1	0g. Citizen of	What Co	
	with 3a or		3453 S. Leisure N	Jorld Blyd				2090	6				•
	death ms 2	era	11. Marital Status	12. Was Decedent E	Ever in U.S.	13. Was Deci	edent of H			y Yes or No-			nican Indian,
ပ	after or Ite	by Funeral Director	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔯 N	lo				Puerto Ric	an, etc.)		ck, Whit	
8	ral', c	l by	3	If Yes, Give Year or Dates:		1 🗌 Yes	ZKI NO	Specify:			Specif	y: wh	ite
21215-0036	72 h	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(4	ecedent's Us Give kind of w	ork done d	during most	of working		16b. Kind of B	usiness/	Industry
12	vithin ne. han	mp	Elementary/Secondary (0-12)	College (1-4or 5	+)	ife. DO NOT							
7	iled v dygie her t	ပိ	12 17. Father's Name (First, Middle, Last)	4		portr	ait p	ainte		iret Middle	sel: Waiden Surnar		ployed
and	ntal hed of	Be	Alfred Lee Co	mba								110)	
Ë	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural" or Items 23s or 28s-f show .marked other than "natural" or Items 23s or 28s-f show .matic event.	스	19a. Informant's Name/Relationship		19h M	Mailing Address	s (Street s			Wheele	City or Town,	State	Zin Code)
Maryland	id 2 s ith an 27 is treu		Jacqueline Blunc			4 Newb					-		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other treumatic event. The Medical Exam is must be rediffed at once.		20a. Method of Disposition		20b. Place of D	isposition (Na	me of		Date		20c. Location		Town, State
Baltimore,	Pages ent of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☑ Donation 5 ☐ Other (Specify		cemetery,	crematory or	otner plac	9)					
票	artm. Forter injure		21. Si sulture Funeral Service icen			22. Name a	nd Addres	s of Facility	1 (EE 17	Baltim		0.5
ä	Depa Impo any ir		Senaul/	1700	ctor	State Baltin		-)	Baltim	ore	Street
			23a. Part1. Enter the disease, or company shock, or heart failure. List only	olications that caused	the death. Do no					spiratory arr	est,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Sei	51.5								one day
	/Medical		resulting in death)	a Due to (or as a	consequence of):							one dug
В	Examiner		Sequentially list conditions.	b									
	p iii	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	a consequence of):							
	and	каш	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to for se	a consequence of				-				
60,	ate be executed hysician and the burial-transit	ical E		200 10 (01 83 1	a consequence or,								
68760,	tificate ng physi as the l	dica	•	d						_			
×	eath certifica attending ph for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy						23d Da	te of del	iven
Вох	atter affor u	ciar	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	1 ☐Live birth 4 ☐ Pregnant at	2 Fetal death	3 ☐Ectopic p 5 ☐ Other (s						nth	Day Year
P.O.	that the death cer ed by the attendir detached for use	hys	9 Unknown	9□ Unknown									
<u>s</u> , Б	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	y P	Part II. Other significant conditions c	4		1		1	1	23e. Did to	oacco use conf	tribute to	the cause of death?
ğ	quire an sig	edt	Coronary arte	ry disea	se, 9	astro	nte	stina	니	1 🗆 Ye	s 2 No	3 □ Pr	obably 4 Unknown
900	aw re	plet	bleeding, hypi	ertensio	N Stro	Ke				24a. Was a autops	n 24b.	Were au	topsy findings available
ž	The I	Completed by	ול ול		,					perform	ned?	death?	
Vital Record	statica ctor,	Be	25. Was case referred to medical examiner?					26. Place	of Death (C	heck only on			
× ×	Physic this ce al dire	2	1 ☐ Yes 2 No	Hospital: Inpatie				4 🗀 14012	sing Home	5 ☐ Reside	ence 6 Oth	er (Spe	cify)
n	ing P	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Tin Year) Inju		28c. Injury Work			l. Describe ho	w injury occur	red	
sio	ttendi death. stor: A	catl	2 Accident investigation 3 Suicide 6 Could not be			М		Yes 2 □ N		Lassina (Cr			10
Division of	or At or At Direct or Direct in by	Certification:	4 Homicide determined	28e. Place of Inju	ıry - At home, farπ :. (Specify)	i, street, facto	ry, office		281.	City or Town		oer or Hu	iral Route Number,
	Hospitel or Attenc 24 hours after death Funerel Director: itely filled in by the t		29a, Certifier 1X Certifying Ph	ysician: To the best of	of my knowledge	dooth convers	f at the tim	o data and	I plana and	dua to the e	nung(a) and mu	20005.00	stated
	Hos 24 hc Fun etely	edical	(Check only 2 Medical Exam	niner: On the basis of and manner sta	examination and/	or investigation	n, in my of	oinion, death	h occurred a	at the time, d	ate and place,	and due	to the cause(s)
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Me	29b. Signature and title of certifier			25	c. License	number		2	9d. Date signe	d (Monti	h. Day, Year)
	- > - 0		Dr. Libric Ken	1. Hona	ئير رئ	I	0058	542		r	ARCH,	09	,2006
			30. Name and address of person who						aia A	ve :	5te 51	5	
			Libuse Heinz-N	lomcilovic	M.D.	i	uhea	ton,	Ma	rylan	ste 51 200	702	
	Sta		31. Date filed (Month; Day, Year)		r's Signature	Sports	Pront Pront	7		9			
	Registr	ar	MAR 1 6 2	nna I Marie	as to do	September 1							

permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or items 23a or 28a-f ehow eny injury or other traumatic event, Ina Madical Exactinar traust be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760, Control to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours elter death.

To the Funeral Director: Altar this certificate has been signed by the attending physicien and completally filled in by the funeral director, page 2 should be deteched for use as the burial-transit

within 24 hours
Within 24 hours
To the Funerel completaly filled

	State of Maryland / Dep	partment of Health and Mental Hygiene	see 1										
		Certificate of Death Reg. No. 0 0 6 0 8 0) 4										
an	Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year											
al	James Lyons Donohue, Sr. 4a. Facility Name (If not institution, give street and number)	MARCH 12, 2006 11:5	J-L M										
er	Saint Joseph Medical Center	Towson Baltimore											
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	ay) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Months Days Hours Min. (Month, Day, Year) Country)											
	201-07-9613 TEM 2DF 86 Yrs. Usual Residence of Decedent	Months Days Hours Min. (Month, Day, Year) Scountry) Sept. 27, 1919 Shamokin, P	Α.										
	10a. State 10b. County 10c. City, Town or	r Location 10d. Inside Cit	Limits										
ctor	Maryland Baltimore County Timoniu	un 1 ☐ Yes	2 ÀNo										
Dire	10c. Street and Number	10f. Zip Code 10g. Citizen of What Country?											
erai	12310 Rosslare Ridge Road unit 502 11. Marital Status 12. Was Decedent Ever in U.S. 13	21093 United States 3. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian.											
핊	Armed Forces? 1 □ Never Married 2⊠ Married 1 □ Yes 2 ☒ No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc.											
d by	3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2점 No Specify: Specify: White											
lete	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gin	scedent's Usual Occupation 16b. Kind of Business/Industry in work done during most of working 6b. DO NOT use retired)											
omp	Elementary/3econdary (0-12) College (1-4013+)	tified Public Accountant Steqman and Asso	c.										
Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)											
To	John Joseph Donohue	Grace Lyons											
		ailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	2										
	Mr. James Lyons Donohue, Jr. (son) 122 20a. Method of Disposition 20b. Place of Dis	sposition (Name of , Date 20c, Location - City or Town State	3										
		uneral Chapel 3/15/2006 Forest Hill, Mary	land										
	21. Signature of Funeral Service Licenses	22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr. 2325 York Road Timonium, Maryland 21093	,P.A										
	23a. P.m. En rt : dise set or complication that caused the death. Do not e strock, or heart failure. Just only one cau is on each line.												
i V	Immediate Cause (Final disease or condition a. CONGESTIVE HEART FAILURE resulting in death)												
	resulting in death) Due to (or as a consequence of):												
<u>-</u>	Sequentially list conditions, if any, leading to immediate b. FIEUMONIA Due to (or as a consequence of):												
Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.												
Exa	resulting in death) Last Due to (or as a consequence of):												
dicai	d												
Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	23d. Date of delivery											
icia	in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) 1 \(\text{Yes} \) 2 \(\text{No} \) 1 \(\text{Ves} \) 1 \(\te	31 lectonic oregnancy	еаг										
Phys	9 Unknown 9 Unknown												
1 by	Part II. Other significant conditions contributing to death but not resulting in the CORONARY ARTERY DISEASE	e underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of de 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ U.											
etec	OONOMINE INTERIL DIGHNOL	24a. Was an 24b. Were autopsy findings a											
d L o		autopsy prior to completion of ca	use of										
BeC	25. Was case referred to medical examiner?	1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one)											
မ	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpati	Communication of Communication (Control Control											
tion;	27. Manner of Death Natural 5 Pending (Month, Day Year) Accident investigation 2 Accident												
ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm,	. street, factory, office 28f. Location (Street and Number or Rural Route Numb	19 <i>1</i> ,										
Cert	4 ☐ Homicide Getermined building, etc. (Specify)	City or Town, State)											
Medical Certification;	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, de 2 Medical Exeminer: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place, and due to the cause(s) and manner as stated. If investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)											
Ž	29b. Signature and title of cartifier \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	29c. License number 29d. Date signed (Month, Day, Year)											
		D 41410 march 13th, 2006.											
	30. Name and address of person who completed cause of death (Item 23a) (Typ												
te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	ER DRIVE TOWSON MARYLAND 21204											
ar	MAR 1 6 2006 Barres & A	garles											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dorothy Marie Davenport March 12, 2006 10:02 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 414 Fairmount Ave. Towson Baltimore County 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 18, 1916 9. Birthplace (State or Foreign Country)
Baltimore, MD. 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 ☐ M 2 🗗 F 89 214-18-1545 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ul Hygiene. other then "naturel", or Items 23a or 28e-1 show vent, the Madical Examinar must be natified at 1 ☐ Yes 2 → No Directo Maryland Baltimore County Towson 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.
Importent: If item 27 is marked other then "naturel", or items 23a or 2 and highry or other traumetic event, the Medical Examinant must be none. 10g. Citizen of What Country? 414 Fairmount Ave. 21286 United States Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Licensed Practical Nurse Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Edward Causion Geogiann Causion ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (son) Mr. Calvin Johnson Davenport, Jr. 414 Fairmount Ave. Towson, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Stevenson A.M.E.Ch.Cem. Sparks, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Euneral Service Licensee 22. Name and Address of Facility
Peaceful Alternatives Funeral&Cremation Ctr.,P.A.
2325 York Road Timonium, Maryland 21093 23a. Part Enter the disease, or complications shock, or leart failure. List only one cause caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on Approximate Interval Between Opeet and Death Immediate Cause (Final disease or condition resulting in death) erebrovascu Pnysician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transit Due to (or as a consequence of): physician s the burial IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) signed by be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Linksow page 2 should 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Ho Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Director: 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 24 hours a Funerel I 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

Hospital or Attending Physicien: The law requires that the death certificate be executed

death.

Box 68760.

P.0.

Division of Vital Records,

the Maryland

Baltimore, Maryland 21215-0036

State Registrar

6701 Joseph Adan 31. Date filed (Month, Day, Year) Adams, M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature 6 2006 MAR 1

dan

Charles St. #4104, Towson, mD 21204

w

Mary Dorsey Unpend item# 23a, 27, 28a-f, perMe 9853 3/21/06 TT State of Maryland / Department of Health and Mental Hygiene 06-01789 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Mary Louise Dorsey Αм March 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4669 Falls Road Baltimore N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Ye 10-16-1921 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Yrs. 220-20-0218 Director 84 Maryland Usuel Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ir then "naturel", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1X Yes 2 No MD NA Baltimore Direct 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 124 W. Franklin Street 21201 USA within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. þ Specify: 3 Widowed 4 Divorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homes other 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event QDCS. 18. Mother's Name (First, Middle, Maiden Sumame, Be Roland Dorsey Mary Francis Dorsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila Jenkins/ Niece 3017 Hanlon Avenue Baltimore, MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 03-17-06 Lansdowne, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility yours Wylie Funeral Home 638 N. Gilmor Street Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Asphyxia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No Completed 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of d ath?

1 Yes 2□ No autopsy performed 1 Yes 2□ No director Be 25. Was case referred to medical 26. Place of Death | Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence MXOther (Specify) Scene 2 XIX Yes 2 □ No 28d. Describe how injury occurred Subject entangled 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After Certification Injury 1 Natural 5 Pending 1 ☐ Yes XXX No 2 Accident investigation Fnd 5:25 A^M a wheelchair seatbelt Fnd 3/13/2006 the the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4669 Falls Rd. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in within 24 hours a To the Funarel [Nursing home Baltimore,MD 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME March 13, 2006 of person who completed cause of death (Item 23a) (Type, Print)

State Registrar tamela E. Surthali

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

111 Penn Street

Baltimore, Maryland 21201

mi

32. Registrar's Signature

			For Stete Registrar		State	of Ma	aryland		artment rtificate			and Me	ental F	lygiene		08057
t	Physicia		1. Decedent's Nam	e (First, Middle EVERE									2. Date of Month	Day	Year 7 2 O C	
	/Medic Examin		4a. Facility Name (i		-	number)			-		Location o	of Death			County of De	
			GENESIS					na binb d. N	If Under		If Under 2	24 Hrs	0 5-1-		ALTIMO	
	Funeral Director		5. Social Security N 217. 09. 62	224	6. Sex 1 🗷 M 2 🗆	- 1	9 (In yrs. Ia 92	Yrs.		Days	Hours	Min.		Day, Year)	9. 6	irthplace (State or Foreign Country) VA
	land bw		Usual Residence of 10a. State	10b. County			10c. City,	Town or Lo	cation							10d. Inside City Limits
	Mary a-f sh ilited	tor	MD	N	A		BALT	1MORE	É							1 A Yes 2 No
	or 28	Funeral Director	10e. Street and Nu	mber					10f. Zip	Code				10g. Citi	zen of What C	Country?
	s 23a	ral	2524 HAI	RLEM A			5:- II O	40.1		1216		-:-0.40		No.	NSA 14 Bass As	nerican Indian,
	fter de r item	Fune	11. Marital Status 1 Never Marr	ied 2 Marr	Armed	Forces?	Ever in U.S lo	_ '	Was Deced If Yes, spec	rfy Cuba	n, Mexican	n, Puerto R	lican, etc.)	Black, Wh	
5-0036	filed within 72 hours after death with the Maryland I Hygiene. other than "naturel", or items 23s or 28s-f show rent, the Medical Examiner must be rotified at	by	3 🖾 Widowed	4 Divorced	If Yes Year	Give or Dates:			1 🗆 Yes 2	No.	Specify:				Specify: BU	ACK
2	n 72 h	Completed	(Spec	15. Decedent cify only highes	t's Education st grade complet	ed)		16a. Deced	tient's Usua kind of wor OO NOT us	l Occupa	ation Juring most	t of working	g	16b. Ki	nd of Busines	s/Industry
7.	filed withir Hygiene. Ither than int, the Me	duic	Elementary/Second 12/11 GRA		Colleg	e (1-4or 5 Δ	+)	91E	_	10R1				BET	н. эте	
מ	e filed Il Hygi other vent,	Be C	17. Father's Name			-						r's Name	(First, Mic	ddle, Maiden		
ylar	should be and Mental I smarked o	ToE	NORFLEE	r ever	ET						ISAB	ELL	CART	ER		
Maryland	C1 (d == 00		19a. Informant's N		1	ECE)		- 27000E	_		_				r Town, State,	, Zip Code)
	ges 1 and tof Health if item 27 or other tr		20a. Method of Dis		H (1912			2524 ace of Dispo		ne of		BAL		MD 20c. Lo	21216 ocation - City of	or Town, State
ē	90===		1 🗷 Burial 2 14 □ Donation		3 □Removal fr pecify)	om State		netery, crer AR H	-	ner piac	1	3.20	·D/ ₂	BAIT	TMORE	MD
Baltimore,	permit. Pag Department Importent: I any in ury c		21. Signature of Fu	0	License		1020	VA	Name and	C. C	s of Facilit	E FUN	JERAL	SERVI	Œ	
	20240		23a. Part1. Enter shock, or		complications th	at caused	the death.	519	51 BAL	TO.N	ATL P	KE.	BALT	OM.	21229	Approximate
	Physician		Immediate Cause	(Final	only one cause	on each lir	ne.		_				,			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	n	a	to (or as	a conseque	ence of):	IIM							"Who
	Examiner		Sequentially list co	anditions.	b	+	14P		EN	510	ow					nenets
7	ed sit	Ine	if any, leading to in Cause (Disease or	nmediate	Due	to (or as	a conseque	,	VE	0						MOHER
V_	be executed sician and burial-transit	Examiner	that initiated event- resulting in death)	s	c. Due	to (or as	a conseque		· V C							101000
8760	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit				d											
9	artifica ing ph e as th	Med	IF FEMALE:													
Box	eath certific attending p for use as	lan/	23b. Was deceder in the past 12		1 🗆 Li	ve birth	of pregnan- 2 Fetal of time of dea	death 3[Ectopic pro						23d. Date of d Month	lelivery Day Year
о. О.	res that the de signed by the a be detached f	Physician/Medical	1 ☐ Yes 21 9 ☐ Unknown			nknown	time of dea	alli SL	Other (sp	вспу)						
	is that jned b	by Pi	Part II. Other signi	ficant condition	ons contributing	to death b	ut not result	ting in the u	nderlying ca	ause give	en in Part I.		23e. [Did tobacco u	ise contribute	to the cause of death?
ğ	w require been sig should b												1	☐ Yes 2	□ No 3 □ I	Probably 4 Unknown
ecc	e law r has be je 2 sh	Completed											a	Was an outopsy	prior to	autopsy findings available o completion of cause of
a H													1 🗆 Y		death'	es 2 No
<u>=</u>	ysician: nis certifica I director, I	o Be	25. Was case reference examiner?		Hospital:	- Innetia	- 205	TP/Outpation	3 00	. Othe		of Death			e Mother (Co	
ō	g Phy er this	\vdash	27. Manner of Dea	th	28a. D	ate of Inju	ry 2	R/Outpatier 28b. Time of		Bc. Injury Work	at	irsing Hom	le 5∐le 8d. Descr	ibe how inju	6 Other (Sp y occurred	овспу)
ion	uttending I death. ctor: After y the funer	atlo	Natural 2 Accident	5 Pendin investig	gation	Aonth, Da	y rear)	Injury	М		<br Yes 2 □ I	No				
Division of Vital Records,	l or Attendate death Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 🗋 Could i determ	ined 288. P	lace of Injudication	ury - At hon c. (Specify)	ne, farm, str	eet, factory	, office		2	8f. Location City or	on (Street an Town, State	d Number or .	Rural Route Number,
	ospite hours merel y filled		29a. Certifier	Certifyin	ng Physician: To	the best	of my know	rledge, deat	h occurred a	at the tim	ne, date an	d place, a	nd due to	the cause(s)	and manner	as stated.
	To the Ho within 24 I To the Fu	Medical	(Check only one)	∠ Medical	exeminer: On the	ne basis of nanner sta	examination	on and/or in	vestigation,	in my of	oinion, dea	in occurre	a at the ti	me, date and	place, and d	ue to the cause(s)
	To To	2	29b. Signature and	title of certifier	ofe N	n			29c	. License	number	_		29d. Da	te signed (Mo	nin. Day, Year)
	1		30. Name and add	ress of person	who completed	ause of d	eath (Item 1	23a) (Tune	Print)	00) > >	150)	MH S.	KUNI	41110006
	4		Sh At	WNM	ALA C	127	A)	965	054	3N	TIA	40	20	40	000	NB14 21041
	Sta	-3	31. Date filed (Mor	ith, Day, Year)	¢ 2000	2. Pugistr	ar's Signatu	Jre .	1. 10	4				-		
	Registr	-		MHK T	o ZUUb	A	ر مستوی	15 P	SE GL							nth. Day, Year) YM ZOO 6 110 MD 110 MD 110 MD
UH	MH 17 Rev 1/2	1017						_								

Echart,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Jr.

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Baltimore City

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

Andrew

Hopkilns

Sex

Hospital

7. Age (In yrs. last birthday)

Sames

The Johns

5. Social Security Number

Physician

/Medical

Examiner

Funeral

utilities 18. Mother's Name (First, Middle, Maiden Surname) Myrtle Gertrude Watkins Buckingham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3655 Ruhl Road, New Freedom, Pennsylvania 17349-9241 20c. Location - City or Town, State Meadowridge Cemetery 3/17/2006 Elkridge, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between nset and Death Mitral Valve Stenosis Years Heart Disease 23d. Date of delivery Month Dav Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy lindings available prior to completion of cause of dealh?

1 Yes 2 No 24a. Was an autopsy performed Yes 2 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mariner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) RES-000 March 12, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe Street, Baltimore, Manyland 32. Plegislrar's Signature **ORIGINAL**

2. Date of Death

8. Date of Birth (Month, Day, Year) May 19, 1926

Month

March

Day

12

Year

2006

4c. County of Death

10g. Citizen of Whal Country?

14. Race - American Indian, Black, White, etc.

Specify: White

16b. Kind of Business/Industry

United States

n/a

7:40 PM

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 ☑ No

Maryland

Registrar DHMH 17 Rev 1/2001

State

Enc J. Hanly M.O.

1 6 2006

31. Date filed (Month, Day, Year) MAR 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 16 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Vaar **Physician** 2 OBAM MARCH 2006 Catherine Helen Fisher /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** ARMIDEL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) APR 24, 19 CLEM BURNIE BASTIMOZE WARHINGTON MEDICAL CENTER Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** 1□M 2XF 215-28-6648 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 Yes 2 No Director Maryland Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 807 Castle Road 21061 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 1 Never Married 2 XMarried If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Department Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph A. Zellman Hilda Fisher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 807 Castle Road Glen Burnie, MD 21061 Franklin E. Fisher/Husband 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit, Pages 1
Department of He
Importent: If iter
any Injury or oth Metro Crematory, Inc. 3/14/06 1 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Juneral Service Licensee

Edward A. Gregorchik 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GREBROVASCULAR Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Yonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b. Time of 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

Division of Vital Records, P.O. Box 68760

requires that the death certificate be executed

use as the burial-transit

ed by the attending physician a

certificate has

this

after death. Director: Af

24 hours a

29a. Certifier

(Check only one)

31. Date filed (Month, Day,

Medical

and

or 28e-f show

238

items

5

"natural',

Hygiene.

Is marked other

ss 1 and 2 should be fi of Health and Mental F item 27 Is marked ot

death v

Baltimore, Maryland 21215-0036

treumatic event, the Medical Examinar must be notified at

State

Hospital or Attending

To the within 2 To the

> 30. Name and addre ss of person who com ABA 501

nus

29c. License number 7.417.46

1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Maxch 13 Glen Burnie Mi

cause of death (Item 23a) (Type, Print) HOSP Ital

6 2006

and manner stated

32. Registrar's Signature

Registrar

		For State I tem#20 Registrar 1. Decedent's Name (First, Middle,			Cei	rtifica	te of L	eath	2. Date o	f Death			e of Death
hysicia Medic		Faith			Faire	:			Month 3	11	2006 Year	1	2:14a ^M
Examin		4a. Facility Name (If not institution, g		er)			y, Town, or l		Death	40	c. County of De		
		Stella Maris H		Ane /in vrs	. last birthday)		imoni	UM If Under 24	Hrs. 8. Date o	f Birth	Baltin		ate or Foreign
neral ector		215–52–7088	1□M 2▼F	59	Yrs.	Months	Days	Hours	Min. (Month	2-15-4	46	Country)	Md.
0	-	Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation						10d Insid	le City Limits
eny injury or other treumatic event, the Modical Examiner must be notified at once.	20		ĮA.		Balt		·e						Yes 2 No
	Irec	10e. Street and Number				10f. Z	ip Code			10g. C	itizen of What (Country?	
181	al D	1811 W. Lexing	ton Stree	t			212	23			USA		
	nuel	11. Marital Status	12. Was Decede	s?	J.S. 13.	Was Dec If Yes, sp	edent of His ecify Cuban	panic Origin , Mexican, F	n? (Specify Yes o Puerto Rican, etc.	r No-	14. Race - An Black, Wh		n,
NAM.	by F	1 Never Married 2 Married 3	1 ☐ Yes 2 If Yes, Give Year or Date	-		1 🗌 Yes	2 X) No	Specify:			Specify:	Black	
	sted	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Us	ual Occupat	tion uring most o	of working	16b.	Kind of Busines	s/Industry	
	Completed by Funeral Director	Elementary/Secondary (0-12)	College (1-4	or 5+)		pect	vork done du use retired)	mig most o	, working	W/a	estingh	ouse	
f. El		12th grade 17. Father's Name (First, Middle, La	ist)		1118	pect		18. Mother's	s Name (First, Mic				
C • V	To Be	James	Edwar	đ	J	ones	}	_	Patty		Mae	Big	gers
n ma		19a. Informant's Name/Relationship				_			or Rural Route No				01010
er tre		Faith Faire	Daug				Riggs .	Ave.	Apt. 3-				21216
or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3			Place of Dispo cemetery, crer	natory or	ame of other place,) 3	Date Date		Location - City of		
olary	1	4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lice	•		King Me		k. and Address	of Facility	3 -15-06		andalls		
eny i) Heada	a 1a20	1-0-			r.H.	•			ore, Md North		.02
for use as the burial-transit	al Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	as a conse	quence of): quence of):								and Death
200	edic		d										
ched for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🐼 No 9 ☐ Unknown	23c. If yes, outcon 1 □ Live birth 4 □ Pregnan 9 □ Unknown	n 2 ∏ Fet tat time of	tal death 3 [⊒Ectopic ⊒Other (pregnancy specify)			-	23d. Date of d Month	elivery Day	Year
uld be detached f	þ	Part II. Other significant condition	s contributing to deat	h but not re	sulting in the u	nderlying	cause giver	n in Part I.			use contribute		
aral director, page 2 should	Completed			<u> </u>					a	Mas an autopsy performed?	prior to death?	completion	ngs available of cause of
ector.	Be	25. Was case referred to medical examiner?	Hospital:				Other		f Death (Check o				
rai dir	5	1 ☐ Yes 2 X No 27. Manner of Death	1 ☐ Inp 28a. Date of I (Month,		28b. Time of		28c. Injury	4 LI Nursi	ing Home 5 ☐ F		6 NOther (Sp ury occurred	ecify) HO	SPICE
<u> </u>	Certification:	1 XNatural 5 Pending 2 Accident investiga 3 Suicide 6 Could no determin	t be 28e. Place of		Injury home, farm, str	M eet, facto	1 🗆 Y	? es 2⊡No	28f. Locati	on (Street a	and Number or I	Pural Route	Number,
9		29a. Certifier 1 Certifying	Physician: To the be	est of my kn	nowledge, death	h occurre	d at the time	e, date and p	place, and due to	the cause(s) and manner	as stated.	/ >
to the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Ex	caminer: On the basi and manner	s of examin stated.	ation and/or in	vestigatio	n, in my opi	nion, death	occurred at the ti	me, date at	nd place, and di	Je to the cau	Se(S)

State Registrar DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

MAR 1 6 2006

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 6:58 AM **Physician** nes 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREURO HARFORD DARRETTSUILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Morth, Day Year) Min. (Morth, Day Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 76 213-26-7217 Yrs. MARYLAND Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10a State 10c. City, Town or Location 10d, Inside City Limits 28a-f show treumatic event, the Medical Exercit at must be notified at HARFORD 1 Yes 2 10 Completed by Funeral Director ARRETTSUKLE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ō or Items 23a 4043 21094 U-ILFORD USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced "naturel", WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OFFICER FOUERNMENT 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GARDNER MARY ERNEST 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 Is any injury or other tre Once. 4043 - VAUGHTER JARRETTSVILLE, 21084 mo 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cometery, crematory or other place)
GARDENS CHARTY
CEMETERY MARCH 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State KUSEDALE, MI) ¹ 4 □ Donation 5 □ Other (Specify) 15, 200G 21. Signature of Fyneral Service Licensee 22. Name and Ad ress of Facility 884c HARFERD RD. 6 ARKUILE MO 21234 CHAPEL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of) Box 68760. Physiclan/Medlcai IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Day Month 4 Pregnant at time of death 5 Other (specify) Vital Records, P.O. detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. anel the 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 30. Imme and ress of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year,

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. Amend 1fem 19a per Th 8853 3-16-06 VI State of Maryland / Department of Health and Mental Hygiene U 6

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** HELEN MARCH GLASER 14 2006 7:34 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE
If Under 1 Year If Under
Months Days Hours MILFORD MANOR NURSING HOME BALTIMORE 24 Hrs. 8. Date of Birth (Month, Day, Yea 02/27/1914 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 F 92 Director 212-07-8055 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a, State other than "naturel", or items 23a or 28a-f show rent, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21208 U.S.A. 4204 OLD MILFORD MILL ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. WHITE 1 Yes 2 No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify. þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME HOUSEWIFE permit. Peges 1 end 2 should be filed Department of Heelth and Mental Hygi Important: If Item 27 is marked other eny Injury or other treumatic event, I 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be HARRISON **JACOBS** FANNIE LOUIS 19a. Ir Park Tame/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 660 STRAFFAN DRIVE #405 - TIMONIUM, MD 21093 -- DEBRA-LANG / DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition (ANSHE EMUNAH) AITZ- CHAIN CONG. 1) Burial 2 Cremation 3 Removal from State 03/15/2006 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory art st. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATherosyles Physician /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? this certificate 1 Yes 2 No ector. 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner eath Certification: Injury 1 Littetural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation of in by the 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) n 24 hours after on Funeral Direct 4 Homicide Hospitel filled 1 🖰 Certifying Physiciam: To the best of the housedge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the ih 8 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier, address of ferson who completed cause of death (Item 23a) (Type, Print) 21136 INECK MO LARRULA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 6 2006 Registrar

ORIGINAL

			For State Registrar	State of Ma	ryland / De		nent o	of He	alth a		ental Hyg	iene ()	6 6	08063
			Registrar 1. Decedent's Name (First, Middle, Last)			oci an	care (01 0	Cairi		2. Date of Deat	eg. No.		3. Time of Death
н	Physici	an	John E. Hou								Month	Day	Year 2006	705 A M
	/Medio		4a. Facility Name (If not institution, give s			4b	City, Tow	vn. or L	ocation o	f Death	March		ty of Death	
	Examin	ıer	1649 Gleneagle 12				Balt			. Dodaii			N/A	
	F1		5. Social Security Number 6. Sex		(In yrs. last birth	day) If t	Under 1 Y	ear I	If Under		8. Date of Birth			place (State or Foreign ntry)
	Funeral Director			IM 2□F		rs. Mo	onths Da	ays	Hours	Min.	SEP 24.	Year)		$v^{ntry)}$
			Usual Residence of Decedent								DDI 2-1	1/41		
	nylan how	_	10a. State 10b. County		10c. City, Town	or Location	n							10d. Inside City Limits
	Be-fa	cto	Maryland N/	A				Ba1	Ltimo	ore_				1 XYes 2 □ No
	ih th or 28	Funeral Director	10e. Street and Number			10	Of. Zip Co	de			1	0g. Citizen of	What Cou	ntry?
	23e	rai	1649 Gleneagle Ro	ad					21239				USA	
	tems ferms	une		 Was Decedent I Aπjed Forces? 		13. Was I	Decedent s, specify	of Hisp Cuban,	anic Orig Mexican	gin? (Spe , Puerto	cify Yes or No- Rican, etc.)		ace - Am <i>e</i> ri ack, White,	
36	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23e or 28e-f ahow ant, the Medical Examinat must be notified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 ☐ N If Yes, Give		1 □ Y	Yes 2【X	No	Specify:			Spec	ify: TT	1-1-
Maryland 21215-0036	hour ural'	D D		Year or Dates:		Decedent's	a Haual O	an in a ti				16b. Kind of		hite
7	"nal	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)		Give kind life. DO N	of work d	lone dui	ring most	of worki	ng	16b. Killd of I	Dusii less/ii	ldustry
12	withi ene. than	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5	+)	B1 ac	cksmi	ith					Rail	road
d 2	filed with Hygiene. other than		17. Father's Name (First, Middle, Last)			DIG.	O LOUIL		8. Mothe	r's Name	(First, Middle,	Maiden Suma		Loud
an	outd be Mental arked o	To Be	Carroll Hours	h						1	Wellie D)onohoe	2	
<u>Z</u>	2 should I and Meni is marker	-	19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. !	Mailing Ad	ddress (St	treet an	d Numbe	r or Rura	l Route Number	, City or Town	n, State, Zij	o Code)
S	C/ c0 = 0		Walter F. Hoursh/	Brother	164	o c1.	enen	-10	Bonne	1 2	ltimore	MIV 2	11230	
re,	t Health tam 27 othar tr		20a. Method of Disposition		20b. Place of I	Disposition cremator	n (Name o	of r place)	Lacte			20c. Location		own, State
10	Pages nent of I ant: If itu		1 ☐ Burial 2 X Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State			•		, i	2/1/.	/06	D.	1+4	ore. MD
Baltimore,	permit. Pages 1 and Department of Health Important: If itam 27 any injury or othar to once.		21. Signature of Funeral Service Hoense	0 0.1	Metro C	22. Nar	me and A	ddress	of Facilit	y C1	emation			MD, Inc.
ä	permit. Departr Imports any inju		Edward A Cro	gorchik		299	Free	deri	ick I		Baltin			
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused	the death. Do no									Approximate Interval Between
	Physician		Immediate Cause (Final											Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as	d Stage a consequence of	f):	cue	MIC		rai	omyoga	()		
	Examiner				, ,	-7-						0		
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter the desired Cause (Disease or injury that initiated events	Due to (or as	a consequence of	f):				·				
	outed id ransit	Examiner	Cause (Disease or injury that initiated events										1	
ó	le be executed ysician and e burial-transit		resulting in death) Last	Due to (or as	a consequence of	f):								
192	ate be nysici he bu	icai		l								· · · · ·		
89 3	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE:									1		-
Box	ath ce	an/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		opic pregn						ate of deliv fonth	ery Day Year
	the at	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 🗌 Oth	er (specif	fy)						
P.0	that the dead by the detached	Phy	Part II. Other significant conditions con	stributing to death b	it not reculting in	tha undark	hina aaua	0.5000	in Part I		23a Did to	hacco lise co	ntribute to t	he cause of death?
S,	ires tha signed d be det	by	Fait II. Other significant conditions con	itilbuting to death b	at not resulting in	are underr	iyiiig caus	e disati	mir airr.			es 2□No		
oro	w requir been s should	Completed												
ec	a law	nple									24a. Was a autops	SV	. Were auto prior to co death?	opsy findings available impletion of cause of
H	The cate I	Co									perforl 1 ☐ Yes	2 NO	1 🔲 Yes	2000
of Vital Records,	Physician: The law this certificate has t ral director, page 2 s	Be	25. Was case referred to medical examiner?	lospital:							(Check only or			
of	> 0 0	2	To Yes 21 TNO	1 Inpatie			DOA	Other:	4 LINU	rsing Ho	ne Preside 28d. Describe h	ence 6 🗆 Ot		fy)
	After uner	lon	27. Manner of Feath 1. ■ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Tii Year) Inj	jury N		Injury a Work?	ռ es 2 🔲 !		zod. Describe ni	ow injury occi	nied	
Sic	Vttendik death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be	28a Place of Init	ıry - At home, farr			_	5 2 🔲		28f Location (S	treet and Num	her or Rur	al Route Number,
Division	after of Dirac	Certification:	4 ☐ Homicide determined	building, et	. (Specify)	III, SIIEEI, I	ractory, or	nice			City or Town		1201 01 1101	as riodio realibor,
_	To tha Hospital or Attending Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral		29a. Certifier \ \ Certifying Phys	sician: To the best	of my knowledge	death occ	curred at the	he time	date an	d place	and due to the c	ause(s) and n	nanner as s	stated
	To tha Hospita within 24 hours To tha Funaral completely filled	Medical	(Check only 2 Medical Examile one)		examination and									
	o thin o thin ompl	₩	29b. Signature and title of certifier				29c. Li	icense r	number		2	9d. Date sign	ed (Month,	Day, Year)
	F S F Ö		De Val	1			10	ಎ೦	578	22		Mone	13	2006
			30. Na e and address of person o co	n pleted cause of d	eath (Item 23a) /T	Type Print	, , ,		578	~_>		, woch	, 13	~000
			110 i	ELL Darles	10 1		700 i	3, 14	Sn	MIS	21239			
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	cina	205				-(2)			
	Registi		MAR 1 6 2006	A >	La Do	41.0								
DH	MH 17 Rev 1/2	1001	WENT T A COOP	A Comment	No post	and the second								
					ORIG	INAL								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 16 Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Lest) Dev Year 13, **HELEN** HITESHEW March 2006 10:35 PM 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not institution, give street end number) Catonsville Baltimore St. Joseph's Nursing Home If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number Months Days Hours 1□M 2QF Yrs APR 16, 1913 214-50-1486 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a, Stete 10b. County 10c. City, Town or Location 1 Yes 2 No Catonsville Maryland Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21228 USA 122 Tugwell Drive 14. Race - American Indian, Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: Specify: 3 ♥ Widowed 4 Divorced White 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) James J. Allenbaugh Mary E. Houck 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Richard A. Hiteshew/Son 611 Oak Hill Road Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □ Removal from State Date 3/17/06 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licenses MacNabb Funeral Home, P.A. Estward B. Treguche Edward A. Gregorchik 301 Frederick Road Catons 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on eech line. 301 Frederick Road Catonsville, MD 21228 Approximate Interval Between Onset and Death . END STAGE ALZHEIMERS DEMENTIA Immediate Cause (Final disease or condition resulting in death) 10 YEARS Due to (or es a consequence of) Due to (or es e consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown ARTERY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? T Yes DEIN 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

Physician /Medical Examiner

attending physician end of for use es the buriel-trensit

been signed by the s should be detached

page 2 s

certificate

this : After thi

death. neral Director: A filled in by tha fu

within 24 hours a

Hospital or Attending Physician: The law requiras thet tha daath cartificate be axecuted

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral Directo

ð

Completed

Be

2

Physician/Medical Examine

þ

Completed

Be

Certification: To

edical

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mantal Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28s-f ahow any injury or other traumatic event, the Medical Examinat must be notified at angles.

altimore. Maryland 21215-0036

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

CORONARY

25.	Was case referrexaminer?	ed to medical
	1 ☐ Yes 2	No
27	Manner of Death	

5 Pending investigation

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rurel Route Number, City or Town, State) certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29a. Certifier (Check only

Natural

2 Accident

3 Suicide

4 - Homicide

end manner steted. 29b. Signature end title of p

D0040012

29c. License number

2006 MARCH 14

29d. Date signed (Month, Dey, Yeer)

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

405 FREDERICK ROAD, SUUTE 204, CATONSULE, MO POUTON

31. Dete filed (Month, Dey, Year) State Registrar

MAR 1 6 2006

6 ☐ Could not be determined



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. -6 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Day Year 2010 **Physician** p_{M} 2006 March 10 Ludwig Hornig /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 22 Arkla Court Catonsville Baltimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** 1**⊠**M 2□ F Yrs 75 1930 Germany Director 217-40-4345 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State or 28a-f ehow traumatic event, the Madical Expression must be notified at 1 ☐ Yes 2 X No Baltimore Maryland Catonsville Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? iteme 23a 22 Arkla Court 21228 United States Pages 1 and 2 should be tiled within 72 hours after death vent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Iteme 23 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐Yes 2XNo 1 Never Married 2X Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) Auto Mechanic City Government 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ပ Ludwia Hornia Freida Dorr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edna A. Hornig / Wife 22 Arkla Court, Catonsville, Maryland 21228 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 6 permit. Page Department of Important: If any injury or once. nation 5 Other (Specify) Loudon Park Cemetery 3/14/2006 Baltimore, Maryland 21 Signature of Funeral Service License 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Luna Ceuncer disease or condition resulting in death) /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for u Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) been signed by the s should be detached it 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s 1□ Yes 2☑No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ij Medical Certification: To this After thi tuneral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural Injury 5 Pending To the hospromer within 24 hours after death.

To the Funeral Director: After the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the fun 1 □Yes 2 □No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Triffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Mennuello 0057936 03-13-2006

DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

900 cotin Ave. Bathmore, mo 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Dr. Heather Mernuel

1 6

31. Date filed (Month, Day, MAR

			For State	State of Maryland		ent of Hea			ene 0 0 E	08066
			Registrar 1. Decedent's Name (First, Middle, Las	st)			1	2. Date of Death		3. Time of Death
٥.	Physici	an	Janet	Harris				Month 3	Day Yee	
	/Medic Examin		4a. Fecility Name (If not institution, give		4b. C	City, Town, or Loc	cation of Death	MD	4c. County of De B2/+6	eath
فبر			5. Social Security Number 6. S		t birthday) If Ur	nder 1 Year If	Under 24 Hrs.	8. Date of Birth		Birthplece (State or Foreign
홣	Funeral Director			□M 2√2 F 88	Yrs. Mon	ths Days H	lours Min.	8. Date of Birth (Month, Day, 1 4/18/191	Year)	Country) OHIO
	14		Usuel Residence of Decedent	00				4/ 10/ 191		OHIO
	/land		10a. State 10b. County	10c. City, 1	Town or Location					10d. Inside City Limits
	Man,	to	MD BALTIM	ORE	GLEN .	ARM				1 ☐ Yes 2X No
	r 288	Director	10e. Street and Number		10f	Zip Code		10	g. Citizen of What	Country?
	A with		11323 GLEN ARM RO	DAD		21057			USA	
	death with the Maryland ims 23a or 28a-f ehow	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was D	ecedent of Hispa specify Cuban, N	inic Origin? (Spe	ecify Yes or No-	14. Race - A Black, W	merican Indian,
9	after or Ite	T.	1 Never Married 2 X Married	1 Tes 2 No			Specify:	1 110411, 0101/	Consider	
3	hours after luret', or Ite	1 by	3 Widowed 4 Divorced	Year or Dates:					Ороспу	WHITE
21215-0036	172 hours after death with the Marylan "naturet", or Items 23a or 28a-f show dical Exam mer munt be notified a	Completed	15. Decedent's Ed (Specify only highest gra		16a. Decedent's (Give kind o	Jsual Occupation f work done durin T use retired)	n ng most of worki	ng 1	6b. Kind of Busine	ss/industry
2	filed within 72 Hygiene. Wher then "na!	dm	Elementary/Secondary (0-12)	College (1-4or 5+)					OWN HOM	E
	led w lygier her ti		12TH GRADE		HOMEM		Mother's Name	(First, Middle, M		L .
Maryland	tal H	Be	17. Father's Name (First, Middle, Last)						aluen Sumame)	
<u> </u>	Mer	ို	ERNEST DIEKMANN		400 14 10 4 4		BLANCHE		City or Town, Stet	a Zin Codol
ā	2 2 2 2		19a. Informant's Name/Relationship (72	•
_	~ ~ ~ L		STEFANIE H. HUNT		42 STRA				MD 2123 0c. Location - City	
0	of T		1 Burial 2 XCremation 3	Removal from State	netery, crematory	or other place)				
Ē	Pag tment tant: I		`4 □Donation 5 □Other (Specif		RO CREMA				CATONSVI	
Baltimore,	permit. Page Department Important: It eny injury o		21. Signature of Funeral Service Licer	J. Hayw	0.200.23	e and Address of 1 LOCH F			i funeral ISON, Mu	HOME, P.A.
20 49	Physician /Medical		23a. ert 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death. one cause on each line. a. Due to (or as a consequer	in (mode of dying, s Pneu	uch as cardiac o	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	b. Due to or as consequer	nce of):	C ()	- 7			
Ć.	The law requires that the death certificate be executed ase base signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a)conseque	e > /	CAL	n Ce 1			
09/89	icate be physicii s the bu	dicai		a. Eighzge	21 5 +	YLET	hand	2		
ŏ	leath certific attending p	√/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnance					23d. Date of	delivery
.O.	that the death ed by the atter detached for t	Completed by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live birth 2 Fetal de 4 Pregnant at time of deat 9 Unknown		ic pregnancy r (specify)			Month	Day Year
0	that I ed by deta	4	Part II. Other significant conditions of	contributing to death but not resulti	ing in the underlyi	ng cause given ii	n Part I.	23e. Did tob	acco use contribut	e to the cause of death?
ds,	signed signed d be det	d b	Chronic a	trizl Fib	orull o	tin	~	1 ☑ Ye	s 2 □ No 3 □	Probably 4 Unknown
Ö	w requir been si should	ete	6 1					24a. Was an	24h Were	autopsy findings available
<u> </u>	has has	E E	Chronic	anemi				autopsy	prior deat	to completion of cause of h?
<u></u>	r. Th		In eugeno	thorax						Yes 2□ No
<u> </u>	itcien: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Other		h (Check only one		Weganines
o	Phys this al dir	. To	1 Yes 2 No 27. Manner of Death	1 12 Inpatient 2 LEF	VOutpatient 3 8b. Time of	J DOA		me 5 Reside	nce 6 Other (5	Specify)
ב	ing l	o	1 ☐Natural 5 ☐ Pending	(Month, Day Year)	Injury	28c. Injury at Work?	2 □ No	200. 2030100 110	Williamy Goodings	
Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificete ha completely filled in by the funeral director, page	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	8 28a Place of Injury - At hom				28f. Location (Str City or Town		r Rural Route Number,
	To the Hospital or within 24 hours after To the Funerel Dirticompletely filled in I	edical C		nysician: To the best of my knowle miner: On the basis of examination and manner stated.						
	To the within 2 To the complet	Re	29b. Signature and title of certifier	1 /		29c. License nu	umber	29	d. Date signed (M	lonth, Day, Year)
			1 X den	LICHEL	no	1000	0639	171	3/14	106
			30. Name and address of person who	completed cause of death (Item 2	3a) (Type, Print)				-/-	1
			Rhonda F. Kn	11		Rose	Blvd	. 132H	more	MD 21239
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	re	1000				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | 6 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Ma Month **Physician** 2006 8:48 A. M James R. Hiatt /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore County Baltimore 528 Castle Drive Apt. C. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 3. 1927 **Funeral** Days Hours Months 506-24-3415 Nebraska 79 **Director** Usuel Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 ☐ Yes 2 No Maryland Baltimore County Baltimore Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21212 United States 528 Castle Drive Apt. C. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 🖾 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) H. Chamber Interior Designer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Grace Faulkers Harry Hiatt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10 Norfork Drive, Maumelle Arkansas, 72113 Jim Hiatt (Nephew) 20c. Location - City or Town, State 20a. Method of Disposition
1 □ Burial 2 △ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 12006 Evans Funeral Chapel Forest Hill, Maryland ¹ 4 □ Donation 5 □ Other (Specify) Peaceful Alternatives Funeral&Cremation Ctr.,P.A. 2325 York Road Timonium Maryland, 21093 23a. Part. Enter the disease, or completitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocordial Physician disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of). artery Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown δ signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown cate has been signated to page 2 should to Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 1 No Hospitel or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Pres 2 □ No 2 this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification; After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by hours after 4 - Homicide N/A 24 hours a Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

12+1

To the within 2

Box 68760.

P.0.

Registrar

Krohe

2006

29a. Certifier

30. Name a

(Check only one)

29b. Signature and tit

Medical

Sul 200 32. Registrar's Signature CASELAR D

10755 Fells Rood, Lutharulle, MD 21893

29c. License number

D44 296

29d. Date signed (Month, Day, Year)

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Print 1 tell 8 per ab 2833 3-16-06 vt.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Month Year March 12, Esther B. Hoover 2006 4:00 AM 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) National Lutheran Home Rockville Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 1917 Months 1 ☐ M 2 🔽 F 88 Yrs. 190-12-3112 Mar 18, 1918 Pennsylvania Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No MD Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9303 Wescott Place #A 20850 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify. Specify: white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 12 teacher education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) J. S. Brant Lola Walker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3827 N. Richmond Street Arlington, VA Vicki Sapp/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) S. Wade 21. Signatus of Funeral Servi Ronal d 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Approximate Interval Between Onset and Death years Pav

Pnysician /Medical Examiner

Physician

/Medical

Examiner

Funeral Director

by.

Completed

Be

ပ

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "netural" ~-" any injury or other traumatic event.

burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed physician the þ this After t death. Director: filled in by the

Division of Vital Records, P.O. Box 68760,

	23a. Part 1. Enter the disease, or com shoot, or heart failure. List only	plications that caused the dear	th. Do not enter the mo	ode of dying, such as cardia	ac or respiratory arrest,	í
by Physician/Medical Examiner	Immediate Cause (Final disease or conhition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		re obstance of: The barrier of: The barrier of: The barrier of:		diseas Levosis Uke mia	e v
yslclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 monthe? 1 □ Yes 2 (□ Ho 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fett 4 ☐ Pregnant at time of c	al death 3 Ectopic			23d. Date of deliver Month
	Part II. Other significant conditions of	contributing to death but not res	sulting in the underlying	g cause given in Part I.	23e. Did tobaco 1 ☐ Yes	o use contribute to the
Completed					24a. Was an autopsy performed 1 Yes 2	
a	25. Was case referred to medical			26. Place of Di	eath (Check only one)	
To B	examiner? 1 Tes 2 Tho	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ [OOA Other: 4 Liversing	Home 5 Residence	6 ☐Other (Specify)
	27. Manner of Death 1 Protural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how in	njury occurred
Certification;	3 ☐ Suicide 6 ☐ Could not be determined		nome, farm, street, factory)	ory, office	28f. Location (Street City or Town, St	and Number or Rural ate)

ise contribute to the cause of death? PNO

Year

Day

3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

6 ☐Other (Specify) ry occurred nd Number or Rural Route Number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

License number 29c

29d. Date signed (Month, Day, Year)

ompleted cause of death (Item 23a) (Type Print)

31. Date filed (Month, Day, Year)

6 2006

nd title of ceftifier

MAR 1

Pagistrar's Signature

State Registrar

Medical

29a. Certifier

29b. Signal

(Check only

within 24 hours a To the Funeral I

3-20-06 vt artment of Health an	d Mental Hygiene 0 6	08069
tificate of Death	Reg. No.	

acı	k Jones	1	Stete Registrar	State of Mai			ificate of L			eg. No.		3. Time of Death
	Physicia	an	Decedent's Name (First, Middle, Last) Jack Jones	2					Month		2006	8:25 A M
i.	/Medic	_	4a. Facility Name (If not institution, give st				4b. City, Town, or	Location of Death			ty of Dealh	
	Examin	eı .	Maryland House of C		s Anne	v	Jessur)		Anne	Arund	el
	Funeral Director		5. Social Security Number 6. Sex 214-58-4903	7. Age	(In yrs. last birt	hday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept 1,	Year)	9. Birthp Cour Mary	place (State or Foreign htry) Land
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loc	alion				1	0d. Inside City Limits
	Mary -1 eho	ţō	Maryland Howard		Je	essu	ıp					1 ☐ Yes 2 No
	r 28a	Directo	10e. Street and Number				10f. Zip Code		1	0g. Citizen o	f What Cour	ntry?
	th wit		P.O. Box 534				207			USA		
Maryland 21215-0036	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do ther then "natural", or iteme 23a or 28a-f ehow event, the Madical Examiner must be notified at event, the Madical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent E- Armed Forces? Yes 2X Notes Yes, Give Year or Dates: 			/as Decedent of Hi Yes, specify Cuba ☐ Yes 2√ No	ispanic Origin? (Si n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	В	ace - Americ lack, White, ify: Whi	etc.
Ö.	72 ho	ted	15. Decedent's Educ (Specify only highest grade	cation completed)	16a.	Decede (Give k	ent's Usual Occupa	ation during most of wor f)	king	16b. Kind of	Business/In	dustry
21	ithin 7.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	.)		O NOT use retired CCT	0		Cons	truct	ion
2	filed w Hygier other th		17. Father's Name (First, Middle, Last)			Labo	rer	18. Mother's Nan	ne (First, Middle,			1011
and	il be fi	Be		C					ian Maho		,	
Ž	2 should be filed within and Mentel Hygiene. Is marked other than eumatic evant, the Me	၉	Joseph R. Jones S		19b	. Mailin	Address (Street	and Number or Ru			m, State, Zip	Code)
<u>8</u>	atth ar 27 is r treu		Frank Jones, Broth		142	210	Williams	Glenn R	oad Char	lotte.	NC 2	8273
re,	of Heer item		20a. Method of Disposition		20b. Place of cemeter	Dispos y, crem	ition (Name of atory or other place	:0)	Date	20c. Locatio	n - City or To	own, Slate
Ĕ	Page nent c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		Cre	matory I	nc. 03/				Maryland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Mante Important: If item 27 is marked eny injury or other treumatic evone.		21. Signature of Funeral Service Life servic	eg-		Cr 29	Name and Address emation 9 Freder	ss of Facility Society ick Road	Of Maryl Baltimo	and Ir	ıc. ırvlan	d 21228
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on		the death. Do	not ente	r the mode of dyin	g, such as cardia	or respiratory ari	rest,		Approximate Interval Between
	Physician	72	Immediate Cause (Final disease or condition		Harr	MA	4					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence	<i>f</i>):	1					
	zxaminer	<u>_</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
	ted	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injuried exerts.	200 10 (01 43 0	3011304401190	J.,.						
	tificate be executed ig physicien and as the burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a	consequence	of).						
68760,	sicial Buri	edical		1								
		led										
P.O. Box	requires that the death cert een signed by the ettendin hould be detached for use a	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 1 4 Pregnant at 9 Unknown	2 Fetal death		Ectopic pregnancy Other (specify)	′			Date of deliv Month	ery Day Year
S, P.	es that I gned by be deta	by Ph	Part II. Other significant conditions con	ntributing to death bu	t not resulting i	n the ur	ndertying cause giv	ren in Part I.	19	1.2		the cause of death?
of Vital Record	w requires t been signe should be								101	- 1		
lec	≥ 0.00	Completed							24a. Was autop		b. Were auto prior to co death?	opsy findings available ompletion of cause of
a H									Yes	2 No	1 Yes	2 No
Zi K	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	nt 2 ER/O	utnation	t 3 DOA Ott		ath <i>(Ch</i> eck o <i>nly</i> o Home 5 ☐ Resid		Other (Snec	MAE Cooms
	Physic this stal di	- T	1 X Yes 2 No P	28a, Date of Injur	y 28b.	Time of	28c. Inju	rv at	28d. Describe h			MAt Scene
ion	Attending or death. actor: After by the fune	atloi	1 Natural 5 Pending 2 Accident investigation	(Month, Day		Injury ENE	المهو	Yes 2 No	Subject	& Lon	ged &	elf
Division	ar decretor	Certification:	Suicide 6 Could not be determined	28e. Place of Inju	ry - At home, fa	arm, sir	eet, factory, office		281. Location (S City or Tox	Street and Nu vn, State)	mber or Rui	ral Route Number,
ō	ital or is efte ral Dir led in	Cer			pris	16			itauge of	Corect		Jessip MD
	To the Hospital or Attending Physimin 24 hours effer death. To the Funeral Director: Affer this completely filled in by the funeral director.	Medical	(Checkforty 2 Medical Exami	sicien: To the best of iner: On the basis of	examination at	e, death nd/or in	occurred at the ti restigation, in my	me, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and date and plac	manner as ce, and due	stated. to the cause(s)
	To the within 2. To the complet	Med	29b. Signature and title of certifier	and manner sta			29c. Licens	se number		29d. Date sig	ned (Month	, Dey, Year)
\	Z × Z		1 (2	alo III				C.M.E.		March	1/1 2	2006
7			30. Name and address of person who co	ompleted cause of d	eath (Item 23a)	(Туре.		∪ • F1 • E1 •		Halti	17, 2	.000
			J. Uffor lo	you m)			Penn Sti	reet Balt	timore	, Mary	land 21201
		ate	31. Date filed (Month, Day, Year)	4.7	ar's Signature	1	- 20 -					
	Regist	rar	MAR 1 6 2	006	w B	feet of	reste					

		-	For State Registrar	State of Maryl		ertment of H			ene 1. No. 0 0 6	08070
i	Physicia		1. Decedent's Name (First, Middle, Last) Sylvia L. Jenkir	าร				2. Date of Death Month March 1	Day Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give st			4b. City. Town, or	Location of Death	March	2 2006 4c. County of Death	10:25A M
	Examin	er	Anne Arundel Med		ter	Annapo			Anne Ar	undel
a_ ,	Funeral Director		5. Social Security Number 6. Sex $217-38-9269$	7. Age (In)	yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Sept 4	(e <i>ar</i>) 9. Birth Cou 1940 Mar	place (State or Foreign ntry) yland
	pu s		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Lo	cation				10d. Inside City Limits
	Manyla 1 eho	ō	Maryland Anne Aru	indel 2	Annapol	is				1X☐Yes 2☐No
	r 28a-	Director	10e. Street and Number		mapor	10f. Zip Code		10	g. Citizen of What Cou	ntry?
	th with		1203 McGuckian S	St.			401		USA	
36	be filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or Itams 23a or 28a-f ehow event, the Madical Exerciper must be natified at	by Funerai	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	 Was Decedent Ever of Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 		Was Decedent of Hi fYes, specify Cuba 1 ☐ Yes - ৠ∰No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: B1	etc.
9-0	2 hou		15. Decedent's Educ (Specify only highest grade	ation	16a. Deced	dent's Usual Occupa	ation	un a	6b. Kind of Business/Ir	
21	within 7 ene. then "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	oo NOT use retired stodian)	P	Anne Arun Community	
121	filed w Hygier other th		12th 17. Father's Name (First, Middle, Last)	0	Cu	Stodian	18. Mother's Nam	e (First, Middle, M.		Correge
Maryland 21215-0036	d be f	To Be	Richard H. Turne	er Jr.				Parker	·,	
ary	2 should be and Mental is marked o	ř	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address (Street	and Number or Rur	al Route Number,	City or Town, State, Zi	p Code)
	and 2 lealth a m 27 is		George Jenkins(•					is, Md.	
Baltimore,	E E		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re	emoval from State		sition (Name of			Oc. Location - City or T	
ţi	. Pages tment of tsnt: If It tsnt: If It		4 ☐ Donation 5 ☐ Other (Specify)		Pa		3-17		Annapolis	, Md.
Bal	permit. Page Department of Importent: If eny injury or		21. Signature of Funeral Service License Zarry M, Re	rese moce	83 8	21 West	St. Ann	napolis,	ry, P.A. Md. 214	
7			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	eations that caused the each line.	death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a con	reter	tail	w			
	Examiner		f	Due to (or as a cor	rsequence of):					
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Directo (or es a co-	uence of):	nue				
	be executed sicien and burial-transit	Examine	that initiated events c.	-						
ó,	ate be executed hysicien and the burial-transit	Ex	resulting in death) Last	Due to (or as a cor	nsequence of):					
8760,	ate tha	dical	d							
O. Box 6	The law requires that the death certifical the has been signed by the ettending ploage 2 should be detached for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome of pr 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	⊒Ectopic pregnancy] Other (s <i>pecify)</i>	1		23d. Date of delik Month	very Day Year
<u>.</u> ت	s that ned by e deta	by Pr	Part II. Other significant conditions con	tnbuting to death but no	t resulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Vital Records,	w requires been sign should be	ed h						1 ☐ Y es	s 2 No 3 Pro	bably 4 Unknown
eco	e law re has be	Completed						24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
Ä	(0	Con						perform 1 Tes 2	ed? death? □No 1 □ Yes	2 🗆 No
Vita	Physicien: Tribis certifical	Be	25. Was case referred to medical examiner?	ospital:		ot 3 DOA Oth	20	th (Check only one		
o	Phys r this ral d	7. To	1 Yes 2 No	28a. Date of Injury (Month, Day Yea	2 ER/Outpatier	II OCIDON	Traising In	ome 5 ☐ Resider 28d. Describe hov	nce 6 Other (Spec winjury occurred	ify)
Division	nding th. ; After e fune	Certification;	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	ar) Injury		k? Yes 2 □No			
Visi	or Attendi after death. Director: A in by the f	tifica	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, st	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
Ö	itel or A irs after rel Direc lled in by									
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune	Medical		ician: To the best of my ner: On the basis of exa and manner stated.						
	othe o the	Med	29b. Signature and title of certifier	/ Stateu.		29c. Licens	e number	29	d. Date signed (Month	, Day, Year)
	->-0		· Cunta:	Han	in his	0 15	3306		3/12/01	5
	6		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type,	Print)	11	poles in		
			Cutis Harris, 4	10 300 Be	Stade R	1 303	00 HAMA	poles h	10 -144	
	St Regist	ate rar	31. Date filed (North Day, Year) MAR 1 6 20	32 Registrar's S	oignature	asis	,			
	ricgist	7 GI		The state of the s	100					

			1 - For State Registrar	State of Maryland		artment of F		nd Mental I	Hygien Reg. N	CUUD	08071
	Physici /Medic		1. Decedent's Name (First, Middle, Last)		-	Jennin	195	2. Date of Month	D.	ay Year 2 200	3. Time of Death
	Examir		4a. Facility Name (If not institution, give str The Johns Hopki	ns Hospita		4b. City, Town, or Baltiv	nore	City		c. County of Dea	
ď	Funeral Director		5. Social Security Number 214–12–2870 6. Sex	7. Age (In yrs. last	Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of (Month)	Birth Day, Year -21-]	9. 81	nthplace (State or Foreign ountry) N.C.
	death with the Maryland ms 23a or 28a-f show Linust be mulliou at	tor	10a. State 10b. County NA NA	10c. City,	Town or Lo	cation timore					10d. Inside City Limits 1 XYes 2 ☐ No
	or 28a-	Funeral Director	10e. Street and Number			10f. Zip Code			10g. C	itizen of What C	ountry?
	s 23a	rall	2530 E. Madison S			2120				USA	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Itams 23a or 28a-f show any injury or othar traumatic event, It a Marical Exercitest natified all ance.	by	11. Marital Status 12 1 Never Married 2 Married 3 Nidowed 4 Divorced	. Was Decedent Ever in U.S. Armed Forces? 1	'	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origii an, Mexican, Specify:	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Am Black, Whi	
21215-0036	hin 72 ho e. an "natur. M. Jic. II	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)		16a. Deced (Give life. L	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of	of working	16b. I	Kind of Business	s/Industry
	ygien ygien har thu		12th grade		Hom	emaker				n Home	
Maryland	ould be fil Mental H arkad ott	To Be	17. Father's Name (First, Middle, Last) Henry	Lig	hfoot		18. Mother's Hatt	s Name (First, Mid Lie	dle, Maide	n Sumame) E11	is
	and 2 sho saith and 27 is m ar traum		19a. Informant's Name/Relationship (Type Audrey Wesson D	aughter-in-la	w 2	ng Address (Street a	dison				
Baltimore,	Pages 1 and of He not: If item ity or other		20a. Method of Disposition 1 Surial 2 Cremation 3 Ren 4 Donation 5 Other (Specify)			sition (Name of natory or other placen.	1	Date 3-17-06		ocation - City of	
Balti	permit. Departir Importa any inju		21. Signature of Funeral Service License	fen	22	Name and Address	ss of Facility	Ba	ltimo	ore, Md.	21202
E			23a. Part1. Enter the disease, o complica shock, or heart failure. List only one Immediate Cause (Final	tions that caused the death.	Do not ent	er the mode of dyin	g, such as ca				Approximate Interval Between Onset and Death
is.	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a conseque	nce of):						5 days
7	pe lisit	nlner	Sequentially list conditions, bif any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	nce of):						
8760, <	icate be executed physician and s the burial-transit	al Examiner	that initiated events c resulting in death) Last	Due to (or as a conseque	nce of):						
687	ficate g phys	edlc	d								
P.O. Box	The law requires that the death certific tie has been signed by the attending pl page 2 should be detached for use as t	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	If yes, outcome of pregnand 1 Live birth 2 Fetal d 4 Pregnant at time of dea 9 Unknown	eath 3	Ectopic pregnancy Other (specify)			_	23d. Date of de Month	livery Day Year
ds, P.	uires that signed by	by	Part II. Other significant conditions contri	buting to death but not resulti	ing in the ur	nderlying cause give	en in Part I.			~	o the cause of death?
	sician: The law requir. s certificate has been si lirector, page 2 should I	Completed							utopsy erformed?	prior to death?	utopsy findings available completion of cause of
Vita	ician: sertific ector,	Be	25. Was case referred to medical examiner?	pital:		Tout.		f Death (Check on	ly one)		
of	Attending Physician: r death. sector: After this certifice by the funeral director, i	. To	1 195 9 110	1-2 Inpatient 2 LE	NOutpatien 8b. Time of		4 14012	ing Home 5 ☐ R			ecify)
o	nding ath. r: Afte e fune	atlor	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Worl	k? Yes 2 □ No		,	,	
Divis		Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	eet, factory, office			n (Street a Town, Stat		ural Route Number,
	To the Hospital or within 24 hours afte to the Funeral Dir completely filled in	edical (29a. Certifier (Check only one) Certifying Physic 2 Medical Examined	ien: To the best of my knowler: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the time restigation, in my op	ne, date and pointon, death	place, and due to to occurred at the tin	he cause(s ne, date an	and manner a d place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	Medical Doc-	tor	29c. License	redmun e	D		ate signed (Mon	th, Day, Year)
	4		30. Name and address of person who comp PRIYA MAKADIA, The	Johns Hopki	3a) (Type, 1	Deinal					
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 6 200	32. Registrar's Signatur	i do	seles,					

			1 - For State of Mary		artment of F		Re	eg. No.	08072	
~	Physici		1. Decedent's Name (First, Middle, Last) Billie Mae Jolly				2. Date of Death	2. Date of Death March 12, 2006 3. Time of Death 8:04 P. M		
1000	/Medio Examin	_	4a. Facility Name (If not institution, give street and number) Sacred Heart Center	4b. City, Town, or Hyatts	ville		4c. County of Death Prince George			
-6	Funeral Director	200-1-1	218-16-1068 1□M 2♥F 8	yrs. last birthday) 32 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		^Y 2 ^{ar} / ₁ 923 N	Birthplace (State or Foreign Country) laryland	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show entry injury or other traumatic event, it a Medical Examination to another traumatic event, it a Medical Examination of the rectified at another.	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George Hyattsville 1□Yes 2√x□No							
		Funeral Director	10e. Street and Number 5805 Queens Chapel Road	10f. Zip Code 20005			10g. Citizen of What Country? USA			
		by	11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Dioroced 12. Was Decedent Eve Armed Forces? 1 98 222No If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cuba	lispanic Origin? (\$ an, Mexican, Puer Specify:	Specify Yes or No- rto Rican, etc.)		American Indian, White, etc. White	
		To Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usua (Give kind of wor life. DO NOT us Homemake			of work done during most of working OT use retired)			6b. Kind of Business/Industry Own Home	
			17. Father's Name (First, Middle, Last) William Jecelin				E. Givens			
	and 2 sho ealth and ! n 27 is me		19a. Informant's Name/Relationship (Type, Print) Cynthia Jolly Daughter	1825	New Hamp		dural Route Number re. NW Ap			
	permit. Pages 1 Department of He Important: if Iten eny injury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, crei	matory or other place	ce)			y or Town, State Maryland	
			21. Signature Funeral Service Lice See	B 30	2. Name and Addre urgee-Hen 631 Falls	ss-Seitz Road, f	Funeral Baltimore,	Home, In Marylan		
	by the attending physicien and by the attending physicien and by the attended for use as the burial-itransit	_	23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d.							
		dicai Examiner								
		Physician/Medical	23b. Was decedent pregnant 1 Live birth 2	2 months? 4 Pregnant at time of death 5 Other (specify)				23d. Date of delivery Month Day Year		
	es tha	Be Completed by Pl	Part II. Other significant conditions contributing to death but not resulting in the unde			ven in Part I.		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Monknown		
	0 5 0			<u>-</u>			24a. Was a autops perform	med?∧ dea	re autopsy findings available r to completion of cause of th? Yes 202 No	
	Physician: The this certificate ral director, pag		25. Was case referred to medical examiner? 26. Place of Death (Check only one)							
	Attending Physical death.	tion: To	Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 41 Nursing Home 5 Hesidence 6 Other (Specify)						Specify)	
		Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (SI City or Town	Location (Street and Number or Rural Route Number, City or Town, State)		
	To the Hospitel or within 24 hours after To the Funerei Direction completely filled in the Funerei Direction of the Funer	Medical C	29a. Certifier (Check only one) 1// Certifying Physician: To the best of my knowledge death occurred at the time date and blace and flue to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
ì	To the within 2 To the complet	Σ	29b. Signature and title of certifier	111	29c. Licens			9d. Date signed (A		
*	m		30. Nam and address of person who completed caus if deat	h (Item 23a) (Type,	Print)	フレンノ	offe ti	March	13,2006 MD, 21047	
	s had St	ate	A N d V e S y la Z a y 36. 31. Date filed (Month, Day, Year) 32. Registrar's	Signature	igon R	oad, E	Micoth	City, 1	M), 21047	
6	Regist	rar	MAR 1 6 2006	A AL A	Torok)					

State of Maryland / Department of Health and Mental Hygiene | | 6 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0938 A M MAR HONES 12 06 LIAM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner MERCY MEDICAL CENTER BALTIMORE MD 6. Sex 1 M 2 ☐ F If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 218-26-9083 73 04-02-1932 Washington, DC Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State worle Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heelth and Mantal Hygiene.

ant: If Hear 22 is marked other than "naturel", or itema 23a or 28a-1 ehow ury or other treumatic event, it a Maclical Exp. il act result to multified. 1X Yes 2 □ No Director MD NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 201 Warren Avenue Apt 108 21230 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify Specify: Completed by 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintainance Supervisor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Laura Jones ဂ္ William E. Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heelth at Important: If Item 27 Is any Injury or other tret once. Angelique R. Jones/ Daughter 4406 Moravia Road Apt 5 Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Garrison Forest Veteran Cem 03-20-2006 Owings Mills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor Street Balto, MD 21217 ner 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final KESPIRATORY FAILURE **Physician** HOURS disease or condition resulting in death) /Medical OBSTRUCTIVE PULMOHARY DISEASE MONTHS Examiner MRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner physician and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical ettending p 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav 4☐ Pregnant at time of death 5 Other (specify) ed by the e Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Jas page 2 perform 1 Yes Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 Inpatient 3□ DOA 2 2 ER/Outpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter death. To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0063326 MAR 12 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEDICAL CENTER, BALTIMORE, MD MERCY KUSH DHOLAKIA 32. Res strar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

2006

			For State Registrar	State of Ma	aryland		artment					giene Reg. No.	006	08074
	Physici	an	1. Decedent's Name (First, Middle, Last)	ith Bon	d Kar	ne					2. Date of De Month March	Day	Year 200	
	/Medic Examin		4a. Facility Name (If not institution, give s		<u>u</u>		4b. City,	Fown, or	Location o		1141		County of Dea	
* *		M	433 Timber Lane	7.4-	- /la la	and the state of t			nvil		9 Date of Ris		ueen Ai	
	Funeral Director		5. Social Security Number 6. Sex 120-54-9803	M 20XF	6 (m yrs. 1a 56	st birthday) Yrs.	Months	Days	Hours	Min.	B. Date of Bir (Month, Da AUG 3,	iy, Year) 1940	9	rthplace (State or Foreign ountry) Maryland
	ס		Usuat Residence of Decedent								1100 3,			
	s 1 end 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23s or 28s-f ehow other trsumatic event, the Modical Examinational be notified at	٦	10a. State 10b. County		10c. City,	Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	the M	Funeral Director	Maryland Baltimor	e		Phoe	nlX 10f. Zip	Code				10g. Citiz	zen of What C	ountry?
	3a or	Di	14028 Blenheim R	oad			,,,,,,		131				USA	ŕ
	ter death	nera		12. Was Decedent Armed Forces?	Ever in U.S	S. 13.	Was Deced	ent of Hi	spanic Ori	igin? (Spec	ofy Yes or Notican, etc.))- 1	14. Race - Am Black, Wh	
36	or lite	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 📉 If Yes, Give			1 ☐ Yes 2						Specify:	
21215-0036	hours tural'	q pa	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates:		16a. Dece	dent's Usua	l Occupa	ation			16b. Kir	nd of Busines	White s/Industry
215	in 72 in "na Medic	Completed	(Specify only highest grade Elementary/Secondary (0·12)		54)	(Give life.	kind of wor DO NOT us	k done d e retired	luring mos)	t of working	g		Financ	
212	d with giene grant the	Com	Lienterically/Secondary (0°12)	5+	,,,	Infor	matio	n Sy			sultan		Institu	ution
Maryland	12 should be filled within hand Mental Hygiene. 7 is marked other then "Irsumatic event, the Mec	Be	17. Father's Name (First, Middle, Last)								(First, Middle		Sumame)	
Z	d Mer narke	L L	John M. Bond 19a. Informant's Name/Relationship (Ty.	ne Prati		19h Maili	ng Address	(Street 2			s Fult		r Town, State,	Zin Code)
Ma	id 2 sl th an 27 is r trsur		Dorothy K. Young/D				•						D 2113	
re,	s 1 end 2 f Health item 27 other tra	li	20a. Method of Disposition		20b. Pla	ace of Dispo					ate		cation · City o	
m 0	Page nent o int: if iry or		1 ☐ Burial 2 🛣 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1	ro Cre	emator	y, I	nc .	3/15/	06	Bai	ltimor	e, MD
Baltimore,	permit. Pages 1 e Department of Hes important: if item eny injury or othe		21. Signature of Foregal Service ticensor	egorchik	P								iety o	f MD, Inc. 21228
***			23a. Part1. Enter the disease, or compli shock, or heart lailure. List only or	cations that caused ne cause on each li	d the death. ne.	. Do not en	ter the mod	e of dyin	g, such as	cardiac or	respiratory a	irrest,		Approximate Interval Between Onset and Death
E.	Physician		Immediate Cause (Final disease or condition resulting in death)	Due to (or as	Bewe	e (0	1 5 some	Les)						Onset and Boath
	/Medical Examiner													
	*	er	Sequentially list conditions, if any, leading to immediate	Delay de Due to (or as	a consequ	ence of):								
	cuted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Onen	CA									lycar
760,	e exection ar	Exe	resulting in death) Last	Due to (or as	a consequ	ence of):								
6876	cate b	dicai		l										
9 x	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rail director, page 2 should be detached for use as the buriat-transit	Physician/Med	IF FEMALE:	3c. If yes, outcome	of pregnar	ncy						2	23d. Date of d	elivery
Вох	death a atten d for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1□Live birth 4□Pregnant a	2 Fetal	death 3	⊒Ectopic pr ⊒ Other (sp						Month	Day Year
P.O.	of the c by the tached	hys	9 Unknown	9 Unknown							1			
	signed to	by	Part II. Other significant conditions con	ntributing to death t	out not resu	Iting in the u	inderlying c	ause give	en in Part I	l.				to the cause of death?
Records,	v requir been si should	Completed												Probably 4 Uriknown
3ec	elaw hasb je2st	mple									24a. Was		24b. Were prior to death?	autopsy findings available completion of cause of
al F	hyeician: The law his certificate has t i director, page 2 s		OS Man area referred to modified						00 Bt		1 Tes	2 No	1 □ Ye	
V:	eicia: s certi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	ent 2 🗆 E	ER/Outpatie	nt 3 DC	Oth	05		<i>(Check only</i> ne 5 □ Res		6 Wither (Sp	Brother's
l of	g Phye er this ieral di	n: T	27. Manger of Death	28a. Date of Inju	ury	28b. Time o		8c. Injun			8d. Describe			Residence
ior	andin ath. or: Aft	atio	1 ☑Naturat 5 ☐ Pending investigation	(North), De	y rour,	ilijuly	М		Yes 2	No No				
Division of Vital	tal or Atters as a street de al Directe ed in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of In building, e	jury - At hor tc. (Specify		reet, factory	, office		2		(Street an own, State		Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami		of examinat		rvestigation	, in my o	pinion, dea	ath occurre	d at the time	, date and	place, and d	ue to the cause(s)
	With To To To To To To To To To To To To To	2	29b. Signature and title of certifier				290			812		29d. Dat	te signed (Mo.	nth, Dey, Year)
			ful The					136	- 661	6453	0 EA #	ľ	March 1	15, 2006
			30. Name and address of person who co		-		-		0,	261	'D /		10 A	
33	St.	ate	31. Date filed (Month, Day, Year)	32. Regist	rar's Signat	ture .	Volta	35 1	ripps	5 481	is=ir	TAMPE	ms -2	1287
	Regist		MAR 1 6 20	06	15 a A	ture	Sell !							
DH	MH 17 Rev 1/2	001	WITH L V 6V	1000000	ABASEL DIS	and the same								

ORIGINAL

		-	State of Maryland / Department of Health and Me 1 - For Amend Item#23a ptI per PHY G853 3/16/06 GF Registrar	ental Hygien	00 06 08075
#1	Physicia	an	1. Decedent's Name (First, Middle, Last) GLADYS TOYCE KTRRY	2. Date of Death Month D March 14.	Day Year 2006 1:30
) :-	/Medic Examin		4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center 4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel
B	Funeral Director		216-20-0731 1□ M 2♥ F 79 Yrs. Months Days Hours Min.	B. Date of Birth (Month, Day, Yea June 2,	ar) 9. Birthplace (State or Foreign Country) 1926 Maryland
	Maryland f ehow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Anne Arundel Pasadena		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the 1 3a or 28a-	I Director	10e. Street and Number 990 Beechwood Avenue 21122	10g. (Citizen of What Country?
936	72 hours after death with the Maryland naturel', or iteme 23a or 28e-f ehow dical Exa niner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Never Married 2 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 3 Never Married 2 Never Married 2 Never Married 2 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 4 Nev	cify Yes or No- lican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	thin	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker	g	Kind of Business/Industry Dusewife & Mother
land 2	be filed Ital Hygi Id other	To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name		eth Ireland
Maryland	nd 2 shoulth and 27 ie m		19a. Informant's Name/Relationship (Type, Print) George S. Kirby (Husband) 19b. Mailing Address (Street and Number or Rural 990 Beechwood Ave., Pa		
Baltimore,	L SE THE		20a. Method of Disposition 1 \(\mathbb{Z}\) Burial 2 \(\mathbb{C}\) Cremation 3 \(\mathbb{R}\) Removal from State 4 \(\mathbb{D}\) Donation 5 \(\mathbb{O}\) Other (Specify) 20b. Place of Disposition (Name of Generalize) Cameriary, cremators or other place) (3/18/		Location - City or Town, State Len Burnie, Maryland
Balti	permit. Page Department of importent: if any injury or once.		21. Signature of Funancial September 22. Name and Address of Facility McCully-Polyniak Fu 237 E. Patapsco Ave	Balto.	Md. 21225-1856
*	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	respiratory arrest,	Approximate Interval Between Onset and Death
	Examiner	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
8760, <	le be executed ysician and e burial-transit	Ical Examiner	resulting in death) Last c. Due to (or as a consequence of):		
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burral-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12_months? 1		23d. Date of delivery Month Day Year
4	luires that i n signed by	۵	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sen. 1e Dementus	23e. Did tobaco	co use contribute to the cause of death? 2 \(\sum \text{No} \) 3 \(\sum \text{Probably} \) 4 \(\frac{1}{2} \text{Unknown} \)
I Records,	The law requirate has been page 2 should	Completed		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2000
Vital	sician: T certificat rector, pa	Be (25. Was case referred to medical examiner?	(Check only one)	
of V	S 50	2	1 ☐ Yes 2 € No Hospital: 1 ★ npatient 2 ☐ ER/Outpatient 3 ☐ DOA ☐ Uner: 4 ☐ Nursing Hom		6 ☐ Other (Specify)
Division o	ding h. After fune	Certification:	VSNatural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No	8d. Describe how in	
Divi	oital or Attenunts after deatl		4 Homicide determined building, etc. (Specify)	City or Town, Si	
	To the Hospital or / within 24 hours after To the Funeral Direction completely filled in b	Medical	29a. Certifier (Check only one) 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place at the my knowledge, death occurred at the time, date and place at the my knowledge, death occurred at the time, date and place at the my knowledge, death occurred at the time, date and place at the my knowledge, death occurred at the time, date and place at the my knowledge, death occurred at the time, date and place at the my knowledge, death occurred at the time, date at the my knowledge, death occurred at the time, date at the my knowledge, death occurred at the my knowledge, death occurred at the time, date at the my knowledge, death occurred at the my knowledge, death occurred at the my knowledge, death occurred at the my knowledge, death occurred at the my knowledge, death occurred at the my k	ed at the time, date	and place, and due to the cause(s)
	To with To con	2	29b. Signature and title of certifier Wp 29c. License number Wp 00 0 5 7 6 3 3		Mar 14, 2006
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tim Woons 2001 medical Production Man	1.5	mar 14,2006 mo 2/701
**	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 1 6 2006 32. Registrar's Signature	-	
DH	HMH 17 Rev 1/2	001			

ORIGINAL

			For State Registrar	State o	of Marylan		artment rtificate			and M	ental Hyg	ene g. No.	6	08076
	Dhysiair	200	1. Decedent's Name (First, Middle				0.1	_			2. Date of Deat Month March		2008	3. Time of Death
	Physicia /Medic	al	Audrey	E		Kocl	n-Gibu				March			4:40 PM M
	Examin	er	4a. Facility Name (If not institution						Location o				ty of Death Arur	ndo1
			Anne Arundel M. 5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1		apoli:		8. Date of Birth			
	Funeral Director		215-10-4265	1 ☐ M 2 🔀 F	88	Yrs.		Days	Hours	Min.	Month, Day, Dec. 11	1917	Ma	place (State or Foreign ntry)
		t	Usual Residence of Decedent				1							
	rylan		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							10d. Inside City Limits 1 Yes 2 No
	Ba-f s	cto	Maryland	N/A		Bal	ltimor							
	vith th	Dire	10e. Street and Number	7			10f. Zip		-		1	og. Citizen of		ntry?
	s 23s	erai	711 Sunnyfield 11. Marital Status		edent Ever in U	IS 13		21225		gin? (Spe	ecify Yes or No-		S.A.	can Indian.
	ter d	by Funeral Director	1 Never Married 2 Married	Armed F						, Puerto	ecify Yes or No- Rican, etc.)		ack, White,	
980	urs at	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, G	ive		1 ☐ Yes 2	Mo No	Specify:			Spec	ify: Wh	nite
20	be filed within 72 hours after death with the Maryland rial Hygiene. ad other than "natural", or items 23s or 28s-(show other than "natural", or items 23s or 28s-(show event, the Madical Examiner must be truitlied at	Completed	15. Deceden	t's Education st grade completed)	16a. Dece	dent's Usual	l Occupa	ation during most	t of worki	ng	16b. Kind of	Business/In	ndustry
21	within ene.	npie	Elementary/Secondary (0-12)	College	(1-4or 5+)	life.	DO NOT us	e retired,)			T.T		
2	e filed within al Hygiene. I other than ' vent, II e III:		12 17. Father's Name (First, Middle,	N/A		Pur	chasin	ig Ag		r's Name	(First, Middle, M	Wester		ectric
anc	ntal Hed of	Ве	Timothy	L231/		McGui	oan			heri				Pfaff
Maryland 21215-0036	s 1 and 2 should be f f Heelth and Mental litem 27 is marked of other traumatic eve	유	19a. Informant's Name/Relations	hip (Type, Print)				(Street a			I Route Number	City or Town		
<u>s</u>	D = - =		John Gibula (S	on)		263	7 Salf	ord	Driv	e Cr	ofton Ma	ryland	1 211:	14
ē,	s 1 and 2 f Heelth item 27 other tra		20a. Method of Disposition			Place of Dispo cemetery, cre	osition (Nam	e of her place	e)	C	ate	20c. Location	- City or T	own, State
Ę	Page nent o int: if		1 ■ Burial 2 ☐ Cremation 1 ■ Donation 5 ☐ Other (S		1 State	oly Cr	-			3/18	/06 I	Brook1	yn Pai	rk Maryland
Baltimore,	permit. Pages 1 an Department of Heel Important: If Item 2 any injury or other once.		21. Signature of Funeral Service	Licensee										ryland 21225
Ω_	89 = 29		John F.	Colline									e, Mai	
			23a. Part. Enter the disease, o shock, or heart failure. List	complications that only one cause on	caused the dea each line.	th. Do not en	ter the mode	of dying	g, such as	cardiac (or respiratory arre	est,		Approximate Interval Between Onset and Death
	Prrysician	1	Immediate Cause (Final disease or condition	_a. Re	Sprut	m	arre	1						
	/Medical Examiner		resulting in death)	Due to	o or as a consec	quence of):								
		-	Sequentially list conditions, if any, leading to immediate	b. Due to	veumu o (or as a consec								-	
	ted nsit	Examiner	Cause (Disease or injury	<	(
	execun n and ial-tra	Exar	that initiated events resulting in death) Last	c	(or as a consec	quence of):								
8760,	The law requires that the death certificate be executed the second the second physician and the second physician and orgen 2 should be detached for use as the burial transit	licai		d										
9	tificat og phy as th	Medi	-											
Вох	leath certifica attending ph I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn birth 2 Tet		□Ectopic pre	egnancy					ate of deliv	rery Day Year
	e dea he att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∏Preg 9∏Unk	gnant at time of a	death 5	Other (spe	ecify)					, on the	Day Tour
P.0	that the de ned by the a detached t	Phy	Part II. Other significant conditi	ons contributing to	death but not re	sulting in the i	inderlying ca	ause divi	en in Part I		23e. Did tol	pacco use co	ntribute to	the cause of death?
ds,	signe d be	d by	Chamin O	be book h	- 6	2 hun	h (dia	PATT) DV	s 2 No	3 ☐ Pro	bably 4 Unknown
Ö	v require been si should b	etec		/3///			8				24a. Was a	n 24t	Were aut	onsy findings available
Records,	The lav ate has page 2	ompieted									autops perform	ned?	death?	opsy findings available ompletion of cause of
		e Co	25. Was case referred to medical	ıl T					26 Place	of Deat	1 Yes	100	1 🗆 Yes	2 □ N 0
Vital	Physician: this certific ral director,	OB	examiner?	Hoonital:	Inpatient 2	ER/Outpatie	nt 3□ DO	A Oth	or		me 5 Reside	-	ther (Speci	ify)
1 of	g Phy er this eral c	n: T	27. Manner of Death	28a. Dat	e of Injury onth, Day Year)	28b. Time o		8c. Injun	v at	-	28d. Describe ho			
Ö	Attending In death. ector: After by the funer	atio	E LI / tooldoint	igation	,	,,	М		Yes 2	No				
Division	or Attendent death Director:	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	ningd 286, Fld	ce of Injury - At t ding, etc. (Spec	nome, farm, st	treet, factory	, office			28f. Location (Si City or Town		nber or Rui	ral Route Number,
	ospital or A hours efter uneral Dire ly filled in by													
	Hosp 14 hou Fune Fune tely fi	ledical	(Check only 2 Medica	ng Physician: To to Examiner: On the	basis of examin	iowledge, dea lation and/or i	th occurred nvestigation,	at the tin in my o	ne, date an pinion, dea	nd place, ath occur	and due to the c red at the time, d	ause(s) and a ate and place	manner as e, and due	stated. to the cause(s)
	To the Hospital or / within 24 hours effer To the Funeral Dire completely filled in b	Med	one) 29b. Signature and title of certifications		inner stated.		290	. Licens	e number		2	9d. Date sign	ned (Month	, Day, Year)
1	F M F O		15		1	M	2 1	101	2057	762	5	inn	- 14	2006
,			30. Name and address of person	who completed ca	use of death (Ite	om 23a) (Type		11/6	N 3 (07		1	1 '	
	[U]		1 in war	06 2v	ul me	diant	no In	rko	m	1	man	11, n	10	21401
	Sta	ate	31. Date filed (Month, Pay, Next	006	Registrar's Sign	natur	Sec. of		4				,	
	Regist	rar	m, iii 2 0 -	17	•									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** OBERT March 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTO 31 KOCK DAK 0 ARKUILLE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, 11/27/ 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sax **Funeral** Months Country) MARYLAND 1 ☐ M 2 ☐ F Yrs 217-22-9872 79 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State Items 23a or 28e-f show 27 is marked other then "neturel", or Items 23a or 28e-f shor treumatic event, the Musical Expedies musical be notified at MD BALTIMORE PARKVILLE 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8631 ROCK OAK ROAD 21234 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? X Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 TXNo Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CADILLAC DEALERSHIP SALESMAN 12TH GRADE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) HARRY KELLY ETHEL LOATZ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ANN M. KELLY/WIFE 8631 ROCK OAK ROAD BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State MORELAND MEM. PARK 3/17/2006 | HILLENDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenses 8521 LOCH RAVEN BLVD. TOWSON, MD 23a-Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Friysician ASCUD disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed for use as the burial-transit attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown ፩ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 Unknown Prosteto Concu 1 ☐ Yes 2 ☐ No Stenos. 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? Pilmones Gestritis 1 Yes this certificate 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending After 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No death. within 24 hours after deatl

To the Funaral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Wind

31. Date filed (Month, Day, Year)

100

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

D0031295

5601 LOCA RAVEN BLUD, P.O.B., Ste 208A, BALTO, MD. 21239

7		F >> D	u
rower as LIVA KATSHAN	Baltimore, Maryland 21215-0036	-	Department of neatin and mental hygiene.

P.O. Box 68760 Division of Vital Records.

1- For Amend Item 23a per Dr., G853, 03/16/06dhb Registrar Registrar Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician 15:17 PM LIYA KATSMAN MARCH 10 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner l of Baltimore 5. Social Security Number 6. S Baltimore N/A If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) DEC. 25, 1914 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) neral Days Months Hours 1□M 2₩F 91 220-33-4828 RUSSIA ector Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or items 23s or 28s-f ehov other traumatic event, the Medical Examinar transities at 1 Ves 2 No N/A MD BALTIMORE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3211 CLARKS LANE #417 USA 21215 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY MUSIC EDUCATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (UNKNOWN) ZABEZHINSKY **VOOLFE** RASYA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2503 FARRINGDON ROAD - BALTIMORE, MD 21209 INNA NEMIROVSKY / GRANDDAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any Injury or o once. 1 X Burial 2 Cremation 3 Removal from State HAR SINAI CEMETERY 03/12/2006 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 2 days HEPATIC FAILURE **Physician** FULMINANT disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hepatitis 5-quartially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine ete hes been signed by the ettending physicien and page 2 should be detached for use es the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 20nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificete hes autopsy performed? 2 No 1 ☐ Yes 2 ☑ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Ph within 24 hours efter death. To the Funerel Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 MARCH 10 2006 MD 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) Sinai MD Hospital KUMAR 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

6 2006

MAR 1

The state of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** LITTLEWOOD 8:30 ELIA 03 0 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Haiford JUBILEE Baldwin Mill Fallston 2778 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🗷 F Days Hours 246-36-1472 Director Feb 14, 1928 North Carolina Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23e or 28e-f show HARFORD EDGE WOOD 1 ☐ Yes 2X No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1949 LONEE 21040 USA or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 7 is marked other then "natural", or items traumetic event, it will mailed Examination 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Be Completed by Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. markad othar then Elementary/Secondary (0-12) College (1-4or 5+) 10 0 registered nurse healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Pages 1 and 2 should be fill timent of Health and Mental Hrant: if itam 27 is marked oth jury or other traumetic evan James Wiley Reedy Belva Testerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Littlewood/spouse 1949 Sidnee Drive Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or once. 4 X Donation 5 Other (Specify) 21. Signature of Euneral Service 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street mon Baltimore, MD 21201 23a. Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASPIRATION PNEUMONIA 3DAYS **Physician** /Medical Examiner OBSTRUCTION & LIVER FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed OVARIAN Due to (or as a consequence of): Box 68760 attending physician for use as the buria IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Division 5 Pending investigation 1 Natural death. 1 Tyes 2 No 2 Accident Diractor: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours aft

To the Funaral Di

completely filled in 🗽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Dav. Year) Or Lucia is

State Registrar 30. Name and address of person who completed cause

31. Date filed (Month, Day, Year)

Franklin

MAR 1 6 2006

M)

of death (Item 23a) (Type, Print

12. Régistrar's Signature

_			1 - For State Registrar	State of M	arylan	nd / Depa <i>Cei</i>	artment tificate	of Healt of Dea	h and M th		iene	06	0808	0
	Physici /Medi		1. Decedent's Name (First, Middle, La John	•	ird1:	inger				2. Date of Death Month March 5		5 Year	3. Time of Dea 12:00	
	Examir		4a. Facility Name (If not institution, giv 14404 Windy Oaks)			wn, or Locati	ion of Death $1b$ oro			ty of Death	eorge's	
	Funeral Director		270 20 20 10	9x ☐ 7. A	96 (In yrs.	last birthday) Yrs.	If Under 1 Months I	Year If Un Days Hou	nder 24 Hrs.	8. Date of Birth (Month, Day, May 21,	Year) 1909	Con	place (State or For	_
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge	eorge's	10c. Cit	y, Town or Lo Upper		oro					0d. Inside City Li	imits
	with the 3s or 28s	Dire	10e. Street and Number 14404 Windy Oaks				10f. Zip C	ode 0772		10	og. Citizen of	What Cou	ntry?	
036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "naturel" or iteme 23e or 28e-f ehow event, it a Medical Exacidar must be redified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 Yes 2 If Yes, Give Year or Dates:	?	1	Vas Deceder	t of Hispanic Cuban, Mex	cican, Puerto	ncify Yes or No- Rican, etc.)	14. Ra	ace - Ameri ack, White, ify:		
21215-0036	hen "	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 1.2 t. h		5+)	(Give	lent's Usual (kind of work 20 NOT use lanica	done during r retired)	most of workii	ng	Manufa	Business/In	dustry	
ਨੂ	should be filed vind Mental Hygie marked other tumetic event, III	To Be C	17. Father's Name (First, Middle, Last) Maximilian Nii	dlinger	280				Elsie	(First, Middle, M Hoffne	r	,		
, Mar	and 2 sho selth and n 27 le m		19a. Informant's Name/Relationship (Debbie Nirdling	Type, Print Daug ger in-1		1440	/ + 1/2/1 0	Juan	S OIIC.	re obber	narr(JULU,	MDZUIIZ	
Baltimore,	permit. Pages 1 and 2 should be Department of Heelih and Menta Important: If Item 27 Is marked ery Injury or other treumetic es <u>once</u> .		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify			Place of Dispo- emetery, cren kland				așe 2006 2 N	Novi,			
Balt	Departition of the control of the co		21. Signature of Edneral Service Use	al M	0015	3 6	533 01	d Alex	andria		Road C		n, MD207	35
	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Scruntially list conditions if any, leading to immediate cause. Enter Underlying	a. Due to (or as	a conseq	Prosh uence of): Wefout		t dying, such	as cardiac o	r respiratory arre	st,		Approximate Interval Between Onset and Death	h —
58760,	ficate be executed physicien and s the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a conseq	uence of):								
.O. Box (that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	t death 3□	Ectopic preg Other (spec					ate of delive	ery Day Year	
ords, P	w requires that the been signed by th should be detache	δ	Part II. Other significant conditions of	ontributing to death t	out not res	ulting in the ur	derlying cau	e given in Pa	art I.		acco use cor s 2 🎇 No		ne cause of death ably 4 □Unkno	
Vital Record	The law ate has b page 2 sl	Completed								24a. Was an autopsy perform 1 ☐ Yes 2		Were auto prior to co death? 1 \(\sum \text{Yes}	psy findings availa mpletion of cause 2□ No	able of
f Vit	Physicien: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpati	ent 2	ER/Outpatient	3 □ DOA	Other	lace of Death Nursing Hon	Check only one		her (Specif	()	
Division of	Jing After fune		27. Manner of Death 1 Statural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		28b. Time of Injury	28c	Injury at Work? 1 Yes 2		8d. Describe how	w injury occu	rred		
Divis	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	ury - At ho c. <i>(Specif</i>)	ome, farm, stre	eet, factory, o	fice	2	8f. Location (Str. City or Town,	eet and Num State)	ber or Rura	l Route Number,	
	To the Hospital or A within 24 hours after To the Funeral Direction completely filled in by	edical	29a. Certifier *** *** *** *** *** *** *** *** *** *	ysician: To the best liner: On the basis and manner st	n examma	wlodge, death tion and/or inv	occurred at estigation, in	he time, date my opinion,	and place, a death occurre	nd due to the car d at the time, da	use(s) and m te and place	anner as si , and due to	ated. the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifier		MY	2		cense numb	. 5	29	d. Date sign	ed (Month.	Day, Year)	
1	6		30. Name and address of person who are Thomas K. Huis				Print)	0051 ouare		Waldorf,	Marv1	and 2	0603	
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registr		ture	uki	1						-

			1 - For State Registrar	State of Maryland		artment of Health			jiene Jeg. No.	06	08081
Ţ.,	*		Decedent's Name (First, Middle, Last)		-,			2. Date of Dea		Year	3. Time of Death
	Physicia /Medic		B1a	nche A. Ott	:			Month March		2006	1:00 P M
)	Examin		4a. Facility Name (If not institution, give str	eet and number)		4b. City, Town, or Locatio	n of Death		4c. Cou	inty of Death	
		, A	Kris-Leigh Assiste			Severna	Park er 24 Hrs.			e Arur	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la 89	st birthday) Yrs.	Months Days Hours	s Min.	8. Date of Birth (Month, Day JAN 29,	1917	Cou	place (State or Foreign ntry) Sylvania
	Director		159-01-6369 Usual Residence of Decedent	09				JAN 29,	1717	I CIII	Sylvania
poland	M H		10a. State 10b. County	10c. City,	Town or Lo	ocation					10d. Inside City Limits
Z d	s - s	ctol	Maryland Anne Arun	de1		Annapolis					1 XYes 2 No
ih th	or 28	Director	10e. Street and Number			10f. Zip Code	2		10g. Citizen	of What Cou	ntry?
dae	s 23s	erai	P.O. Box 4491	2. Was Decedent Ever in U.S	13	21403		acify Yes or No-	14. 6	USA Race - Ameri	can Indian.
fter d	Itam	Funeral	11. Marital Status 1 Never Married 2 Married 12	Armed Forces? 1 ☐ Yes 2 X No		Was Decedent of Hispanic (If Yes, specify Cuban, Mexic		Rican, etc.)		Black, White,	
	o',la	by	3 ∰Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ᠓No Speci	ity:		Spe	ecify: W	hite
	natu	Completed	15. Decedent's Educa (Specify only highest grade		(Give	dent's Usual Occupation kind of work done during m	ost of works	ng	16b. Kind o	of Business/Ir	dustry
d d	han.	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		siness Owner			Λ,	ntique	Chon
1 6	Hygie ther i		17. Father's Name (First, Middle, Last)		bu		ther's Name	e (First, Middle,			SHOD
9 2	ked o	To Be	Roger Atkinson				Edith	Wood			
Y 10	and Marial Hygiene. Is marked other than "natural", or itams 23s or 28s-f show raumatic event. Ita Madical Extrainer roust be notified at	-	19a. Informant's Name/Relationship (Type	e, Print)	19b. Maili	ng Address (Street and Nun	nber or Rura	al Route Numbe	r, City or To	wn, State, Zij	Code)
, pue	a Fault and Mantal Hygiene. Heath and Mantal Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event. Its Mantal Exemples roust be notified at		Robert A. Warden/S	on		. Box 4491 Ar					
5 5	f Iter		20a. Method of Disposition 1 ☐ Burial 2 ②Cremation 3 ☐ Re	moval from State	metery, cre	osition (Name of matory or other place)		Date		on - City or T	
	rtmen rtant: njury		4 Donation 5 Other (Specify) 21. Signature of Tuneral Service Licenses			ematory, Inc.		.4/06		timore	
	pennic. rages failed. Department of Health a Important: if Item 27 is any injury or other tra		thward A. fry	nell_		2. Name and Address of Fa 299 Frederick					
			23a, Part 1. Enter the disease, or complication	orchik ations that caused the death.						1110 21	Approximate Interval Between
P	hysician		shock, or heart failure. List only one Immediate Cause (Final	~	nen	tie					Onset and Death
<u> </u>	/Medical		disease or condition resulting in death)	Due to (or as a consequ	ence of):						in the second
¥0	xaminer		Sequentially list conditions, b.								
7	Sit S	nine	cause. Enter Underlying Cause (Disease or injury	Due to or as a consequ	ence otj:						
,	al-tran	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequ	ence of):					-	
or ou,	physicien and the burial-transit	dical	d.								
	ng phy as th	(a)	IF FEMALE:					_			
XOC S	ttendii or use	hysician/M	23b. Was decedent pregnant in the past 12 menths?	 c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 	death 3[Ectopic pregnancy			23d.	Date of delive	ery Day Year
5	the a	ysici	1 ☐ Yes 2 【 No 9 ☐ Unknown	4□Pregnant at time of de 9□ Unknown	ath 5[Other (specify)					
	Vieduries that the death centric been signed by the attending p should be detached for use as	by Ph	Part II. Other significant conditions cont	ributing to death but not resu	Iting in the u	ınderlying cause given in Pa	art I.	23e. Did to	bacco use o	contribute to	the cause of death?
Spinosa Spinosa	n sign n sign ald blu	d b						1 □ Y	'es 2□N	lo 3□Pro	bably 4 □Unknown
ברים ברים ברים	s been si	ompleted						24a. Was autop		4b. Were aut	opsy findings available ompletion of cause of
The lower free free free free free free free f	ate ha	Com						perfo	med? 2 No	death?	
VILAI	ertifica ector.	Be	25. Was case referred to medical examiner?				ace of Deati	h (Check only o	ne)	,	Assiste
5	this c	J.	1 Yes 2 No		ER/Outpatie 28b. Time o		-	me 5 Resid			Living
	After After funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work? M 1 ☐ Yes 2		200. 2000	,,		
VISION	r deal	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, st	reet, factory, office		28f. Location (S		umber or Rui	al Route Number,
5	s afte el Dir	Certification:	4 Homicide	building, etc. (Specify	<i>,</i>			ony or row	on, orano,		
1	To the nospite of Atentining Frigstrent: The far within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	edical	(Check only 2 Medical Examin	cian: To the best of my knower: On the basis of examinat	vledge, dea ion and/or ir	th occurred at the time, date evestigation, in my opinion, i	and place, death occuri	and due to the red at the time,	cause(s) and date and pla	d manner as ace, and due	stated. to the cause(s)
	thin 2 the mplet	Med	29b. Signature and title of certifier	and manner stated.		29c. License numb	er		29d. Date si	igned (Month	, Day, Year)
)	- 3 F 8		1000.7			D 40	1519		Maro	ch 14,	2006
			30. Name and address of person who cor	npleted cause of death (Item	23a) (Type	, Print)			TIGE (· 179	2000
			Mirza M. Nusa			Madison Park,	Suite	e 100, (Glen E	Burnie	MD 21061
	Sta Registr	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure	Jarles .					

DHMH 17 Rev 1/2001

		•	for State Registrar	State of Maryland /	Department of I		Mental Hygier	2006	08082
	Physici		1. Decedent's Name (First, Middle, Last		12A	RKER	10-0-1	Day Year	3. Time of Death
)	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	2	or Location of Death		4c. County of Death	J
ļ	Funeral Director		5. Social Security Number 6. Se	X 7. Age (In yrs. last t		If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea June 32, 195	ar) /Cour	place (State or Foreign
	Maryland -f show	'n	Usual Residence of Decedent 10a. State 10b. County		wn or Location				10d. Inside City Limits 1 ★Yes 2 □ No
	vith the M	Directo	10e. Street and Number		10t. Zip Code	_	10g. (Citizen of What Cour	
	er death v Items 23s	Funeral Directo	2503 Falking un+ 1 11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of If Yes, specify Cub		ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
-0036	72 hours after death with the Marylan "natural", or Items 23a or 28a-f show disal Examinat must be notified at	ed by F	3 Widowed 4 □ Divorced 15. Decedent's Edu	1 Tes 2 No If Yes, Give Year or Dates:	1 Tyes 2 No	pation	16b.	Spedity:	AMEXICAN
C1717	d within 72 giene. ir than "ne	Completed by	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done life. DO NOT use retire DEL: Store	during most of work		Safeway	food The
/land	uld be file Mental Hyg irked othe itlc event,	To Be C	17. Father's Name (First, Middle, Last) Robert Small	wood		18. Mother's Nam	e (First, Middle, Maid ne Sm A	enteumame)	
, mary	and 2 sho selth and h n 27 is ma		19a. Informant's Name/Relationship (T) BRAWIEY Parker	-(Son) 6	9b. Mailing Address (Street		AUE BALL	HIMERE MA	ngland 2123
More	Peges 1 annount of He ant: If item ary or oth	100	20a. Method of D sposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State	of Disposition (Name of tery, crematory or other pla	MARCH	21,2006 OKE	Location - City or To	. /
Balt	permit. Departr Importe any inje		21. Signal e of Funeral Service Licens	elde	22. Name and Address Solvery Control Solvery C	RANKLIN SI	FUNERAL Freet BAH	Lewice	/
	Physician		23a. Part 1. Ente / V e disease, or comp shock, or 1 e rt failure. List only o Immediate Cause (Final disease or condition	lications that caused the death. Di ne cause on each line.				,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulling in dealh)	Due to (or as a consequence 13) 24 TE	e of): RAZ PN		^		13 5495
	be executed icien and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence.	IMMUN	DEFIL	ENLY 3	YNDROMI	E UNKNOW
8/60,	ate he he	ca	resoluting in double) East	Due to (or as a consequence	e or):				
O. BOX 6	ath certif attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at lime of death 9 Unknown		су		23d. Date of delive Month	ery Day Year
coras, P.	w requires that the de been signed by the should be detached	5	Part II. Other significant conditions co	ntributing to death but not resulting		ven in Part I.		o use contribute to t	he cause of death?
Hecor	elas has je 2	Completed		VENDUS SU		ABUSE	24a. Was an autopsy performed	? death?	opsy findings available impletion of cause of
N N	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital: 1 ⊠Inpalient 2 □ ER/0	Output all post of		1 Yes 2		
on or	nding Phy th. : After this s funeral d	ıtlon: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		D. Time of 28c. Injury Wo	ury al ork?	28d. Describe how in		<i>y</i>)
DIVISION	al or Atter s after dea il Director ed in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, elc. (Specify)	farm, street, factory, office)	28f. Location (Street City or Town, St		al Route Number,
	To the Hospital or Attending Pl within 24 hours alter death. To the Funerel Director: After it completely filled in by the tunera	Medical (29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exam	rsician: To the best of my knowled iner: On the basis of examination and manner stated.	ige, death occurred at the t and/or investigation, in my	ime, date and place, opinion, death occur	and due to the cause red at the time, date	e(s) and manner as s and place, and due to	tated. o the cause(s)
)	To t To t	×	29b. Signature and title of certifier	Bolahi no		se number	29d.	Date signed (Month,	
	10	1 000		· PATEZ, ND	a) (Type, Print) 13 o	N SELL	URB HO	35PITA2	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Pigistrar's Signature	_	100.2			
DH	MH 17 Rev 1/2	2001			ac				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1) (2)

			For State Registrar	State of Maryla		artment of rtificate of		Mental Hyglen Reg. N		08083
	Physici /Medio		1. Decedent's Name (First, Middle, La	Robins	on			" lakh	ay Year	
	Examin	er	4a. Facility Name (If not institution, giv	e street and number)	Rehab	4b. City, Town,	or Location of Deal		c. County of Dea NA	th
	Funeral Director		222 23 2332	ex 7. Age in y	rs. last birthday) 75 Yrs.	If Under 1 Yea Months Day	r If Under 24 Hrs	8. Date of Birth	9. Bir Co	thplace (State or Foreign ountry) Md.
	yland now		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	he Man	Director	Md. NA	A	Balt	imore				1 X Yes 2 □ No
	th with t	al Dir	1712 Milton Ave			10f. Zip Code 212		10g. C	Citizen of What Co USA	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If Item 27 is marked other then "natural", or Items 23a or 28e-f show appropriately or Items 23a or 28e-f show appropriately or other traumatic event, the Medical Examinar must be notified at ODEs.	Completed by Funeral	11. Marital Status †☆ Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 💢 N	Hispanic Origin? (S ban, Mexican, Puer o Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit Specify: B.	erican Indian, le, etc. lack
2-0	"natur	leted	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. Dece	dent's Usual Occi	upation e during most of wo	rking 16b.	Kind of Business	/Industry
212	d withir glene.	Somp	7th grade	College (1-4or 5+)		ant Oper			aplan Gra	ain Co.
and	d be file ental Hy ked oth c event	To Be (17. Father's Name (First, Middle, Last, William		Robins	on		me (First, Middle, Maide Inie	· · · · · · · · · · · · · · · · · · ·	rmer
Maryland 21215-0036	nd 2 shoul	Ė	19a. Informant's Name/Relationship (Clinton Robinson	Type, Print) Brother	19b. Mailir 5200	ng Address (Stree Midwood	et and Number or R. Ave., Ba	ural Route Number, City altimore, Mo	or Town, State	Zip Code) 2
Baltimore,	Pages 1 and the south of the so		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)	Indinoval Ilolii State		sition (Name of matory or other pi mount Ce			Location - City or altimore	
Balti	Deputh Deputh Imports any nju		21. Signature of Funeral Service Licer	Ser Ser	22	Name and Add March E	ress of Facility	Paltir 1101 E.	nore, Md North A	
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the di one cause on each line.	my c	er the mode of dy	ying, such as cardia	chemic		Approximate Interval Between Onset and Death
	/Medical Examiner			Due to (or as a cons	sequence di):	regit	Ja Ja	ilure		J
$\sqrt{}$	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (br as a cons	equence of):	Arte	in a	iseasc		
68760,	tificate be executed g physicien and as the burial-transit	edical Exa	resulting in death) Last	Due to (or as a cons		ibn	Hation			
P.O. Box 68	The law requires that the death certifics sie hes been signed by the attending plage? Should be detached for use as it	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preduction of the second of the s	etal death 3 [Ectopic pregnan	су		23d. Date of de Month	livery Day Year
	quires that in signed b	Ď	Part II. Other significant conditions of	ontributing to death but not in Abus	resulting in the u	nderlying cause g	iven in Part I.	23e. Did tobacco		o the cause of death?
Vital Records,	a 8 C	Completed	4) (24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
/ital	cian: ertifice ector, p	BeC	25. Was case referred to medical examiner?	Hassitali				1 Yes 2 ∧ N ath (Check only one)		
Division of \	To the Hospital or Attending Physician: The I within 24 burs after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	tlon; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year,	ER/Outpatien 28b. Time of Injury	28c. inj		lome 5 Residence 28d. Describe how inj		cify)
Divisi	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not be determined		t home, farm, str			28f. Location (Street a City or Town, Sta		ural Route Number,
	he Hospit n 24 hour he Funera pletely fille	Medical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my lander: On the basis of exam and manner stated.	nowledge, death ination and/or in	n occurred at the vestigation, in my	time, date and place opinion, death occu	e, and due to the cause(urred at the time, date a	s) and manner as nd place, and due	s stated. to the cause(s)
)	To t com	Σ	29b. Signature and title of certifier Amatur A	1 Morem	ME	29c. Licer	nse number	29d. D	ate signed (Mont	n, Day, Year) D 2006
	_ 1		30. Name and address of person who	N NAF	EM, 5	Print) D	olphin	st Bal	imore	2 MP7
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 6 2	32 Registrar's Sig	nature	refer.	1			

State Registrar 31. Date filed (Month, Day, Year) MAR 1

3

CREMER

32. Registrar's Signature

BALTI.

			for State Registrar	State of Ma	arylan		artment of rtificate of				jiene eg. No.	6	08085
П	Physici	an	Decedent's Name (First, Middle, Last,							2. Date of Dea Month	th Day	Year	3. Time of Death
	/Media	cal		ry Paul	ine	Schia			of Doodh	3	14	06	7:20 AM
	Examir	ner	4a. Facility Name (If not institution, give St. Agnies Ha	SPITA			4b. City, Town,	mor Location				ty of Death	
	Funeral		5. Social Security Number 6. Sec	7. Ag	e (In yrs. i	last birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Birth (Month, Day)			place (State or Foreign
	Director		213-01-5003]M 21XF	9.	3 Yrs.	Months Days	Hours	Min.	MAR 16	1912		yland
	and **		Usual Residence of Decedent 10a, State 10b. County		10c. City	y, Town or Lo	ocation					1	0d. Inside City Limits
	Maryl f sho	to	Maryland Baltin	nore		Cato	nsville						1 ☐ Yes 2 XNo
	r 28a	irec	10e. Street and Number			oate	10f. Zip Code			1	0g. Citizen o	of What Cour	ntry?
	23a o	Funeral Director	46 Melvin Avenue	<u>)</u>				21228				USA	
	tams	uner		12. Was Decedent Armed Forces?		S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Or oan, Mexicar	igin? (Spe n, Puerto	cify Yes or No- Rican, etc.)		ace - Americ lack, White,	
36	rs afte	by F	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ X \f If Yes, Give Year or Dates:	10		1 ☐ Yes 2 📉 No	Specify:			Spec	oity: Wh	ite
21215-0036	within 72 hours after death with the Maryland ene. then "netural", or Itams 23e or 28e-f show is Modical Exp: tiret must be notified at	ted	15. Decedent's Edu	cation		16a. Dece	dent's Usual Occu	pation			16b. Kind of	Business/In	dustry
21	s within 72 ho piene. r then "netu rre Medical	Completed	(Specify only highest grad	College (1-4or 5	+)	life.	kind of work done DO NOT use retire	adinig mos ad)	a or worki	ng			
72	77		12 17. Father's Name (First, Middle, Last)			Cash	nier	18 Mothe	er's Name	(First, Middle, I		eteria	l.
and	be d lata	o Be	James H. Schiaf	fino				io. Motific		cy Susan			
Maryland	2 should by and Menta is markad sumatic ev	To	19a. Informant's Name/Relationship (Ty			19b. Mailir	ng Address (Stree	t and Numbe					Code)
	12 mg		Mary Linantud/Nie	ce		101	Beaumont	Aven	ue (Catonsvi	lle, l	MD 212	28
Baltimore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	20b. P	face of Dispo emetery, crea	sition (Name of matory or other pla	ice)	C	ate	20c. Location	n - City or To	own, State
ţi	Department of I Department of I mportent: If it any injury or o		' 4 ☐ Donation 5 ☐ Other (Specify)		Lor	raine	Park Cen	etery	3/18	3/06	Wood1a	awn, M	D
Bal	permii Depar Impor any in			regorchik		19	301 Fred	lerick	Road	l Catons	ville		
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only of	ications that caused ne cause on each lir	the death	n. Do not ent	er the mode of dy	ing, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
	Fnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	un	a) 1	bolun	unle					5 days
П	Examiner				a consequ	derice of).							,
	B =	ner	if any, leading to immediate	Due to (or as	a consequ	uence of):							
	ecuter and trans	Examine	Cause (Disease or injury	Due to (e. e.									
8760,	icate be executed physician and s the burial-transit	icai E		Due to (or as	a consequ	derice oi).							
687	ficate physis the	edic		d									
Вох	death certifica attending ph for use as ti	M/W	230. was decedent pregnant	3c. If yes, outcome 1 ☐ Live birth			Ectopic pregnanc	27/			23d. [ate of delive	огу
O. B	The law requires that the death certificate be executed tie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown	4□Pregnant at 9□Unknown			Other (specify)	· y			N	Month	Day Year
Q	that the		Part II. Other significant conditions con	ntributing to death b	ut not resu	ulting in the u	nderlying cause g	ven in Part I		23e. Did tot	pacco use co	ntribute to th	ne cause of death?
Records,	quires n sign ald be	ed by	Ollypna	will will	n th	pracie	kyphin	un		1 □ Ye	s 2 No	3 🗌 Prob	ably 4 Unknown
000	law requir is been si 2 should	ompieted	V				0 0			24a. Was a			psy findings available
I Re		Com								autops perform	ned? 2€ Mô	death?	inpletion of cause of 2 No
Vital	cian: ertifica ector,	Be (25. Was case referred to medical examiner?				1-		of Death	(Check only on	e)	elled the least	
of	Physician: this certific ral director,	7	1 Yes 2 No	lospital:		ER/Outpatier	IL 3L DOX			ne 5 Reside			/)
on	ling After une	tion	1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injui (Month, Day	Year)	Injury	Wo	ork?]Yes 2□		.od. Describe no	ow injury occ	unea	
Division	of or Attending after death. I Director: After d in by the fune	Ifica	3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At ho	me, farm, str	eet, factory, office		- 2	28f. Location (St		nber or Rura	I Route Number,
Ö	tal or rs afte el Din ed in b	Certification;	4 Holiticide	building, etc	с. (Specify	<i>'</i>)				City or Towr	i, State)		
	To the Hospital or within 24 hours after To the Funerel Direction completely filled in	edicai	29a. Certifier 1 Certifying Physical Check only 2 Medical Exemi	sicien: To the best oner: On the basis of and manner sta	examinat	wledge, deatl tion and/or in	n occurred at the t vestigation, in my	ime, date an opinion, dea	nd place, a th occurre	and due to the ca	ause(s) and r ate and place	manner as si e, and due to	ated. the cause(s)
	To the To the comp	Σ	29b. Signature and title of certifier	6 1				se number	10		9d. Date sign		
•			Vama & B	erebles:	MO		22	1 //	4	<i>h</i>	narch	14,0	00k
			Jama & S 30. Name and address of person who co	ompleted cause of d	eath (Item	23a) (Type, SUL)	Print) DAV	BALL	EME	RE, M	QRYLK	wo.	1 12 29
	Sta		5 4/1 0LD FREE 31. Date filed (Month, Day, Year) MAR 1 6 2006	32. Registra	ar's Signal	ture	10						
4.	Registr	ar	MAR 1 6 2006	The state of the s	CITAL DE	at of							

SR MARY SCHIAFFIND

			For State Registrar	State of Mar		artment of H			giene) 06	08086
N/s	Physicia	20	1. Decedent's Name (First, Middle, Last)	-				2. Date of Dea Month	11 Pay 2006 Yeer	3. Time of Death
	/Medic		Anna Marie Sche			4. O't. T.	Landing of Door			9:40 a M
	Examin	er	4a. Fecility Name (If not institution, give st 5717 Edmondson Ave			Catonsv	or Location of Deatl ille	n	4c. County of Dea Baltimor	
	Funeral		Social Security Number 6. Sex	7. Age (i	n yrs. last birthday,	If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl (Month, Day	9. Bir	thplace (State or Foreign
3	Director		Usuel Residence of Decedent	M 2DXF 83		Months Days	Hours Min.	May 18	3, 1922 M	aryland
-	show	_	10a. State 10b. County		Oc. City, Town or L					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
9	28a-f	Director	Maryland Baltimon	ce	Catons	7111e			10g. Citizen of What Co	
4	Sa or	וב	5717 Edmondson Ave	enue		212	28		United Sta	•
1	ms 2;	Funeral		2. Was Decedent Eve Amed Forces?	er in U.S. 13.	Was Decedent of H		pecify Yes or No-	14. Race - Am	erican Indian,
020	ges I and a Should be filed within 7.2 hours after beath with the waryand. Health and Mental Hybene. If itsm 27 is marked other then "naturel", or items 23a or 28a-f show or other traumatic svant, the Medical Examinant intelliged at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:		1 ☐ Yes 2X No		o rican, etc.)	Black, Whi	
ביים ביים היים ביים	e. Sn "natur Medical	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wor	rking	16b. Kind of Business	/Industry
7	ygien har th nt. the	Con	12	0	Adn	inistrat			Maryland S	tate Gov.
	z should be fried wiffill and Montal Hygiene. Is marked other than aumatic avant, the Montal Hygiene.	To Be	17. Father's Name (First, Middle, Last) Unknown				Anna Br		Maiden Sumame)	
aly	and Men ls marke raumatic		19a. Informant's Name/Relationship (Typ						r, City or Town, State,	
≥ ;	fealth fealth fm 27 fher tr		Wendy G. Shaffer 20a. Method of Disposition					, Lot #7	, Baltimor 20c. Location - City or	e, MD. 21227
2	nent of h		1 ☐ Burial 2 🖺 Cremation 3 ☐ Re	moval from State	20b. Place of Disponentery, cre	matory or other pla	<i>сө)</i>	4/2006	Baltimore,	
			4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses		_				neral Home	-
0	Deporting Supporting S		1 FU		4	107 Wilke	ens Avenu	e, Balti	more, Mary	land 21229
100			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the cause on each line.		ter the mode of dyi	ng, such as cardiad	or respiratory ar	rest,	Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition	C	ngstil	He he	eart.	faile	ul	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a o	on ,er uence of):	•	l	1		0
	THE WEST	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a o	consequence of):					
4	nd nd transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events c.							
, 0	cate be executed physicien and the burial-transit		resulting in death) Last	Due to (or as a o	consequence of):					
700	physi s the I	dical	d.							
YOU O	The law requires trait the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 N No 9 ☐ Unknown	c. If yes, outcome of 1 ☐ Live birth 2 { 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	□Ectopic pregnanc □ Other (s <i>pecify)</i> _	у		23d. Date of de Month	livery Day Year
L 3	ned by ned by e deta	by Ph	Part II. Other significant conditions cont	ributing to death but r	not resulting in the	ınderlying cause gr	ven in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
	aquire en sig ould b	ed b	Diabetes,	Hype	ADDIC	1		1 🗆 Y	'es 20 No 3□P	robably 4 Dunknown
מבי ב	siciani. The law re s certificate has be- lirector, page 2 sho	Completed						24a. Was autop	sy prior to med? death?	utopsy findings available completion of cause of
	Tificat	0	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes ath Check only o		s 2□ No
> }	his ce 1 direc	To B	examiner? 1 Tes 2 No	ospital: 1 Inpatient	2 ER/Outpatie	nt 3□ DOA Ott	her: 4 Nursing H	lome 5XResid	lence 6 □Other (Spe	icify)
	Attending Firsterian. In death. Sector: After this certifically the funeral director.		27. Manner of leath 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	(ear) 28b. Time (Wo	ryat rk?]Yes 2 □ No	28d. Describe h	ow injury occurred	
= :	effer des	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (reet, factory, office		28f. Location (S City or Tow	Street and Number or R n, State)	ural Route Number,
	To the nospina or attaining riystcan. The within 24 hours after dealth. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	cien: To the best of ref: On the basis of earth manner state	camination and/or in	th occurred at the tinvestigation, in my	ime, date and place opinion, death occu	e, and due to the curred at the time, o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	within To the	Me	29b. Signature and title of certified	1/		29c. Licen:			29d. Date signed (Mon	th Day, Year)
	/		· Karfal	2. Girg	5	D3	31724	>	3/14/0	6
	6		30. Name and address of person who con	npleted cause of dea	th (Item 23a) (Type	Print)				

DHMH 17 Rev 1/2001

State Registrar Dr. Raafat L. Girgis 724 Maiden Choice Lane, Catonsville, Maryland 21228
31. Date filed (Month, Day, Year) 32 Registrar's Signature

			1 - For State Registrar		ryland / Depa <i>Ce</i>	artment o	f Health a of Death		Reg. No		6 08087
Н	Physici	an	1. Decedent's Name (First, Middle, Last) Sue V. Snyder					2. Date of Month	Da		M
	/Medio Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Tow	m, or Location o	March f Death		. County of De	8:48 AM
	Ladiiiii		Baltimore Washin	gton Medic	al Center		n Burni		A	nne Ar	undel
	Funeral		5. Social Security Number 6. Security Number 109-36-6422	7. Age	(In yrs. last birthday) 68 Yrs.	If Under 1 Ye Months Da	ear If Under 2 ays Hours	Min. (Month,	Day, Year		Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		00			May 1	7, 19	3/ Ma	aryland
	arylan ehow det	Ē	10a. State 10b. County MD Anne Aru	n de 1	10c. City, Town or Lo						10d. Inside City Limits
	the Ma	Funeral Director	MD Anne Aru	inder	Gambr	10f. Zip Coo	do		10a C	itizen of What	1 Tyes 2 No
	3a or	0	626 Florida Place	2			21054		10g. C		Country
	death	nera		12. Was Decedent E Armed Forces?	ver in U.S. 13.			gin? (Specify Yes or , Puerto Rican, etc.)	No-	USA 14. Race - Ar Black, W	merican Indian,
36	s after	by Fu	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates:	0	1 □ Yes 2 📆		,			white
21215-0036	2 hour	ted t	15. Decedent's Edu	cation	16a. Dece	dent's Usual Oc	ccupation		16b. i	Kind of Busine	
215	ithin 7 ne. nen "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5-	-) (Give	DO NOT use re	one during most stired)	of working			
7	illed w Hygier ther th		9 17. Father's Name (First, Middle, Last)	0	wa	itress	18 Mothe	r's Name (First, Mid		cestaur	ant
au	id be in ked o	To Be	Frank Martin Metz	ler Sr				Elmire I			
Maryland	2 shou and M le mar		19a. Informant's Name/Relationship (Ty			_	reet and Numbe	r or Rural Route Nu	mber, City		a, Zip Code)
გ გ	l and lealth im 27 her tr		Cindy Tillman/dau 20a. Method of Disposition	ghter	626 20b. Place of Dispo			Gambrills Date		21054	or Town, State
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Important: if Item 27 is marked other then "natural", or Iteme 23a or 28a-f show emportant: if Item 27 is marked other then "natural", or Iteme 23a or 28a-f show emportant: if Item 27 is marked other then "natural" he motified at once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☒ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, crei	matory or other	place)	Dais	200. 1	ocation - City	or rown, state
aĦi	mit. P pertme portan y injur		21. Signature / Funeral Syrvice License	e / h	22	2. Name and Ad	ddress of Facility	1 (55.		1	
<u> </u>	30 E 5 8		Ronald S.	LINE_	Ba	altimor	e, MD	oard 655 T 21201		ltimore	Street
			23a. Part Enter the disease, or compli shock or heart failure. List only or Immediate Cause (Final	cations that caused to ne cause on each line	the death. Do not ent	ter the mode of	dying, such as	cardiac or respirator	y arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as fa	consequence of):	y au	tente				
	Examiner		Sequentially list conditions,)	<i>J.</i>	,					
	ped 11s	lner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		consequence of).						
	axecut	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of):						
8760,	icate be executed physician and s the burial-translt	ical	(,								
9	artifica ing ph e as th		IF FEMALE:								
Вох	ettend for us	lan/	in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetal death 3	Ectopic pregna				23d. Date of o Month	delivery Day Year
P. O.	that the death certific ed by the ettending p detached for use as	Physiclan/Med	1 Yes 2 No 9 Unknown	9□ Unknown	and or obtain 5	1 Other (specin)	//		_		
	8 5 g	þ	Part II. Other significant conditions cor	tributing to death bu	t not resulting in the u	nderlying cause	given in Part I.		_		to the cause of death?
ord	w requir been si should	eted								!□No 3□ -	
Records,	hast ge2s	Completed			· · · · · · · · · · · · · · · · · · ·			24a. W	/as an utopsy erformed?	death	autopsy findings available to completion of cause of ?
	ysicien: The is certificate he director, page	0	25. Was case referred to medical				26. Place	of Death Check on	s 2∐N Nonel	o 1□Y	es 21 No
>	Physical this ceral direct	To B	examiner? 1 ☐ Yes 2 No	lospital: 1 Minpatien		nt 3 DOA	Other: 4 Nu	rsing Home 5 🗆 R	esidence	6 □Other (S	pecify)
o uc	sing P n. After t funera		27. Manner of Jeath 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o		Injury at Work? 1 ⊟ Yes 2 ⊟ h	28d. Descri	be how inju	iry occurred	
Division of Vital	Attending Physicien: r death. ector: After this certifice by the funeral director, i	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur	ry - At home, farm, str			28f. Locatio			Rural Route Number,
á	rs efter at Dire ed in b	Certification;	4 Homicide determined	building, etc.	(Specify)			City or	Town, Stat	e)	
	Hospital 24 hours e Funeral I	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examination	ner : On the basis of (f my knowledge, deat examination and/or in	h occurred at th vestigation, in r	ne time, date and my opinion, deat	d place, and due to the time to the time.	the cause(s	s) and manner od place, and d	as stated. lue to the cause(s)
	To the Hospital or Attending I within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	Mec	29b. Signature and title of confider	and manner stat	Фч.		cense number		29d. Da	ate signed (Mo	onth, Day, Year)
	> - 0		> 801/1/A			D	3895	8	3/	9/0	6
			30 Name and address of person wo ac	impleted cause of de	A A 10	Print)	1	0.00	1 6	2	MD21061
	Sta	10	31. Date tijled (Month, Day, Year)	32. Flegistra	Signatura A	un M	y hway	SW OR	m 13	ume	WD 4100/
	Registr		MAR 1 6 20	106 Day	as St. My	Mind all amount	/				

		1 - For State Registrar	State of Maryl	and / Depa		Health and M	lental Hygi	iene () (6	08088
Physic	ian	Decedent's Name (First, Middle, Last)					Date of Death Month	h Day Year	3. Time of Death
/Medi		Willard B.			11 Ch T	1	March	15 2006 4c. County of Dea	
Exami	ner	4a. Facility Name (If not institution, give st				or Location of Death		Baltimor	
Funeral		Gillcrest Hospice 5. Social Security Number 6. Sex		yrs. last birthday)	Towson If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		thplace (State or Foreigountry)
Director		577-26-1741 Usuel Residence of Decedent	^{M 2□F} 9		Months Days	Hours Min.	Jan. 24	, 1916 Wes	st Virginia
ırylan show	_	10a. State 10b. County		. City, Town or Lo					10d. Inside City Limit
r the Marylan r 28s-f ehow	ecto	Maryland Prince Geo	rge	Hyattsvi				. 0 (148 0	ty∑Yes 2□N
th with t	al Dir	10e. Street and Number 7402 Allison Stree	t.		10f. Zip Code	20784	10	og. Citizen of What Co USA	ountry?
r dea	nuel		. Was Decedent Ever i Armed Forces?	in U.S. 13.	Was Decedent of If Yes, specify Cut	Hispanic Origin? (Spo pan, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
hours after death with the Maryland tural', or Items 23a or 28a-f show at Examinar must be notified at	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1□Yes 2√2 No			Specify: W	nite
72 h	etec	15. Decedent's Educa (Specify only highest grade	ition completed)	16a. Dece	dent's Usual Occu kind of work done	pation during most of work ad)	ing	16b. Kind of Business	/Industry
d within 72 giene. ir than "na!	E E	Elementary/Secondary (0-12)	College (1-4or 5+)		ressman	9d)		Evening St	ar
	ပိ	17. Father's Name (First, Middle, Last)			1 Cooman	18. Mother's Name			
ould be Mental arked c	To Be	Lida B. Stark				Etta	Unavaila	ab1e	
and and	-	19a. Informant's Name/Relationship (Type Virginia Stark/Wife			-	St., Hyat		City or Town, State, MD 20784	
Health Health tem 27	10	20a. Method of Disposition			osition (Name of matory or other pla			20c. Location - City or	
permit. Pages Department of t Important: If Ite any Injury or of	1.8	1 ☑ Burial 2 ☐ Cremation 3 ☐ Read 4 ☐ Donation 5 ☐ Other (Specify)	novar nom State			1	106	Prontroad	MD
arit. F Bertme Cortan Injur		21. Signature of Fungral/Service Licenses			coln Cem 2. Name and Addr		/00	Brentwood	, MD
Deperiment of the series of th		+ alph is) Mel	(- I	art Fina	oln Funera ensburg Rd	1 Home Brent	wood, MD	20722
Physician /Medical /sicien and e parigi-litansit	Examiner	23a. Part1. Enter the disease, or complicion shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	e New insequence of):	l ta	ilve			Approximate Interval Between Onset and Death A Y S
× w	Completed by Physician/Medical Ex	d.	Due to (or as a con	egnancy Fetal death 3 [⊒Ectopic pregnand] Other (specify) _			23d. Date of de Month	livery Day Year
es that igned to be deta	y P	Part II. Other significant conditions control	1 /	resulting in the u	- 1	1 12	23e. Did tob	acco use contribute to	o the cause of death?
w require been sign	ed	Chronic oustru	tivelungdi	(SEASE)	1 Swemic	WHAT disen	JC 1 □ Ye	s 2 □ No 3 P	robably 4 Unknow
et or Ci	omple	Diabole Mellitus, per	Thein Vaccil	nvd isease			24a. Was an autopsy perform	prior to death?	utopsy findings availat completion of cause o
eician: The la certificate ha irector, page à	BeC	25. Was case referred to medical examiner?				26. Place of Deat		<u> </u>	
Phyeician: this certific al director,	2	1 Yes 2 No Ho	spital: 1 Inpatient	2 ER/Outpatier	IL SLI DOA		me 5 Resider	nce 6 Other (Spe	city) tospice
ding Phy h. After thi funeral		27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time o	We		28d. Describe ho	w injury occurred	
i dite	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sp	At home, farm, str		Yes 2 No	28f. Location (Str. City or Town,	reet and Number or R , State)	ural Route Number,
Hoepital 24 hours a Funstal letely filled	Medical C	29a. Certifier 1 Certifying Physi (Check only 2 Medical Examine one)	cian: To the best of my or: On the basis of exar and manner stated.	knowledge, deat mination and/or in	h occurred at the t vestigation, in my	ime, date and place, opinion, death occuri	and due to the cared at the time, da	use(s) and manner a ate and place, and du	s stated. e to the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certifier	file;	urs	29c. Licen	se number	29	9d. Date signed (Moni MAVCL /	th, Day, Year) 15, 2006
		30. Name and address of person who com	pleted cause of death	(Item 23a) (Type,	V-Cha	les St.	Balto	. md z	1204
St. Regist	ate	31. Date filed (Month, Day, Year)	32 Registrar's S	ignature	a. K. 3				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 4a per doc 18 per th 9853 3-21-06 vt.

State of Maryland / Department of Health and Mental Hygiene 16

1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Faith L. March 13, 2006 Smith 5:18 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Soputhern Maryland Hospital Clinton Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 30, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min 1 M 2 XX 1930 223 36 5435 Washington DC Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Mudical Exacult or manife notified at 1 ☐ Yes 2 ☐ No Director Maryland Prince George's Temple Hills 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 5101 Yorkville Road 20748 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after XX Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: White þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 ie marked other than "soly fijury or other traumatic event, the Mesone. College (1-4or 5+) Elementary/Secondary (0-12) Claims Adjuster Insurance 12 18. Mother's Name (First, Middle, Maider Surname) Westcamp 17. Father's Name (First, Middle, Last) Be Mary Elizabeth Westeam William Ligon Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Margaret White (Sister) 1619 Lewis Ave, Rockville, MD 20851 20a. Method of Disposition

XX Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate Cedar Hill Cemetery March 17, 2006 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityLee Funeral Home, Inc 6633 Old 21. Signature of Funeral Service Licenses m01284 Alexandria Ferry Road, Clinton, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Embolus ulmonam **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ tenosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown page 2 should Be Completed MelhFus 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autoosy performe Cellulins leas O 2 X No 1 ☐ Yes 2 ☐ No certificate 1 Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No hin 24 hours after death. the Funerel Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 \ Homicide Hospitel 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completely fil Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of pertifier 29d. Dale signed (Month, Day, Year) 52741 "Livington Rd Ft Washing 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2006

			1 - For State Registrar	State of N	Maryland / De	partmen <i>ertificat</i>				•	giene Reg. No.	006	0809	0	
			Decedent's Name (First, Middle,	Last)						2. Date of Dea Month	ath Day	Year	3. Time of De	ath	
	Physici /Medio		Georgia	Or1e	ena	Shool	ζ			MARCH	12	2006	5:06 A	A M	
	Examir		4a. Facility Name (If not institution,	give street and numbe	r)	4b. City,	Town, or	Location of	of Death		4c. County of Death				
			MEMORIAL HOSPIT					LAND				LEGANY			
	Funeral Director		5. Social Security Number 218–16–4683	5. Sex 7. / 1 ☐ M 2 [X] F	Age (In yrs. last birtho 81 Yrs	Months		If Under Hours	Min.	8. Date of Birti (Month, Day) Feb. 9, 1	Day, Year) Country)				
	D		Usual Residence of Decedent								,,,,				
	rylan how	_	10a. State 10b. County		10c. City, Town o	r Location							10d. Inside City L		
	Ba-f	ct	MD. Allegar	ny	Cumberl	and							1 ☐ Yes 2		
	or 2	<u>Pie</u>	10e. Street and Number			10f. Zip	Code				10g. Citiz	en of What Cou	ntry?		
	ath v	rai	10301 Christle		.= :			01-02			U.S.				
	er de Item	Funeral Director	11. Marital Status	12. Was Deceder	nt Ever in U.S. s?	If Yes, spe	dent of Hi cify Cuba	ıspanıc Ori ın, Mexicar	n, Puerto i	cify Yes or No- Rican, etc.)	. 1	 Race - Ameri Black, White 			
Maryland 21215-0036	permit. Pages 1 and 2 should be tited within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Iteme 23a or 28a-f ehow any injury or other treumatic event, the Medical Examinar must be notified at 2006.	by F	1 Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	lf Yes 2√ If Yes, Give Year or Dates	5:	1 🗌 Yes	2 X No	Specify:				Specity: Wh	nite		
ŏ	2 hou	Completed by	15. Decedent		16a, D	ecedent's Usua	al Occupa	ation	مانداد می کی د		16b. Kin	d of Business/Ir	ndustry		
215	thin 7	ηpie	(Specify only highest Elementary/Secondary (0-12)	College (1-40		ive kind of wo fe. DO NOT u	se retired	during mos 1)	a or workii	ng					
7	ygien Frith	ပ္ပ	9		Pa	cker-Tu	ıbe: l					ly Sprir	gfield		
nd	tal H	Be	17. Father's Name (First, Middle, L							(First, Middle,					
78	ould Men narke	ဥ	George William S		101.1		(2)			ight Fe			0.41		
Mai	d 2 st h and 7 te n treun	ì	19a. Informant's Name/Relationsh			•	•					Town, State, Zi	o Code)		
ر. رو	1 and Heatt		Mary D. Lemon -S	rster	20b. Place of D					larman N		ZIO// ation - City or T	own, State	- 1	
Baltimore,	ages int of t: if it		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		Meadowr:			1 1	March						
뵬	orten orten injuri	V	21. Signature of Funeral Service L		19420918	22. Name ar			200	_		idge, M			
Ba	Ped Tipe		(Daniel	Q LLS	1				DIL			ral Hom			
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that caus	ed the death. Do not							., 110. 2	Approximate Interval Between	en.	
	Physician		Immediate Cause (Final disease or condition		PSIS								Onset and Dea	ath	
	/Medical		resulting in death)	_ a	as a consequence of)								70 60		
	Examiner		Sequentially list conditions	D	ements &								untens	wn	
	Po #	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	as a consequence of)									·	
	and I-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	as a consequence of)										
8760,	icate be executed physicien and s the burial-transit	ical E													
687	ficate p phys			d.											
Box	leath certific attending p I for use as t	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcon		- 55-					2:	3d. Date of deliv	ery		
m.	death	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ❤️No		2 Fetal death at time of death	3 □Ectopic pi 5 □ Other (sp						Month	Day Yea	.r	
<u>Ф</u> .	at the by the	Phys	9 ☐ Unknown								-				
Records,	The law requires that the death certifics ate has been signed by the attending pt page 2 should be detached for use as t	by	Part II. Other significant condition	is contributing to death	but not resulting in th	e underlying o	ause give	en in Part I				se contribute to :]No 3 ☐ Pro	he cause of deat bably 4 Unki		
CO	s been si should b	Completed								24a. Was		24b. Were aut	opsy findings ava	ulable	
æ	The la	mo									sy med? 2 No	prior to co death? 1 \(\sum \) Yes	mpletion of caus 2€ No	e of	
ital	rtifica	BeC	25. Was case referred to medical					26. Place	of Death	(Check only o		163	220110		
>	nysici nis ce direc	To E	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	itient 2 ER/Outpa	atient 3 DC	DA Othe	er: 4 🗌 Nu	ırsing Hor	ne 5 🗆 Resid	lence 6	Other (Speci	fy)		
0	ng Pl (fter th		27. Manner of Death Natural 5 Pending	28a. Date of Ir (Month, L	njury 28b. Tim Day Year) 1nju		28c. Injun Work			28d. Describe h	ow injury	occurred			
sio	tendi leath. tor: A the fu	cati	2 Accident investigation in Suicide 6 Could not	ation	h	М		Yes 2							
Division of Vital	after d Direct	Certification;	4 Homicide determine	286. Place of	Injury - At home, farm etc. <i>(Specify)</i>	, street, factor	y, office		2	281. Location (S City or Tow	itreet and m, State)	l Number or Rur	al Route Number	;	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has sompletely filled in by the funeral director, page 2.	Medical C	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the be xaminer: On the basis and manner	of examination and/o	eath occurred or investigation	at the tim	ne, date an pinion, dea	nd place, a	and due to the dead at the time, of	cause(s) a	and manner as place, and due	stated. o the cause(s)		
	Withir To th compl	Me	29b. Signature and title of certifier	-Q				e number				signed (Month,			
)			Mende			1	60)4-	18		31	13106	, a		
			30. Name and a dress of person w	no completed cause o	f death (Item 23a) (Ty	pe, Print)			.0						
			Dr Afaq Ahr	nad, Joh	nson Hei	ghts	Me	dice	al P	oldg, C	uml	be-lan	d, MD 2	1502	
	Sta Registi		31. Date filed (Month, Day, Year)	32. Regis	strar's Signature	7				0.					
	rtegisti	el.	J. MAN	CULID TELES	10 A	Santa Plan									

Please Type or Print in Black Indelible Ink Fashre All Copies Are Legible.
Amend Item 19a per int 853 3-17-00 VI Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene] 6 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 3:22 AM **Physician** HERBERT THOMAS 14 Mzrch 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner of Baltimore Baltimore Sinai Hospita If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Birthplace (State or Foreign Country)

GA 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sax **Funeral** Months Days 1**⊠**M 2□ F Yrs. 11.01.1944 Director 216.42.4553 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f shov notified at 1 Yes 2 No NA Director MD BALTIMORE death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò USA 5607 GIST AVENUE 21215 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 反 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or items 11. Marital Status Black, White, etc. ortant: if Item 27 is marked other than "netural", or Iter injury or othar traumatic event, Ite Medical Examinar filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 M Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) DISABLE 121H GRADE NA 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any jury or othar traumatic event one. 17. Father's Name (First, Middle, Last) GEORGIA BELL JAMES HENRY LEE THOMAS 19a. Informant's Name/R, lationship (Type, Print)
YOLANDA MARIE (DA) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 144 BETHNAL RD. (DAUGHTER) BALTIMORE MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03.16.2006 BALTIMORE, MD GREENMOUNT 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE 21. Sign ture of Funeral Service Licensee Vaughn 5151 BALTO, NATE PIKE, BALTO, MO 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonary
Due to (or as a consequence of): Physician Edama /Medical Chronic Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Diabetes Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical pertension IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 PER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Mannes of Death 1 Natural 5 Pending investigation To the Hospital or Attending within 24 hours after deeth.

To the Funarel Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No М 2 Accident 6 Could not be determined 3 🗀 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and fittle of certifier 29c. License number D43476 March 15, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 W. Belvedere Ave, Battimore MD Sinai Hospital Broderick J. Franklin, MD 32. Reistrar's Signature 31. Date filed (Month, Day, Year) State 2006 Registrar 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2006 10:46 PM Vear Physician March Shirley Trotter /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner madral Washington Burnalt Anna If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 2 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** 1 □ M 27 F 216-86-5621 35 Yrs. Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show of 2 should be filled within 72 hours after deeth with the Maryla lith and Mantal Hygiene. S27 Is merked other than "natural", or items 23a or 28s-1 show traumatic avant, Its Macical Esamiliar count be notified as 1 ☐ Yes 2 No Anne Arundel Severna Park Mary1and Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21146 223 Ritchie Hwy USA Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Amed Forces? 1 ∐ Yes 2 M∑No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cashier Restaurant 9th 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hanna Brown Larry A. Murray ဥ JOPE, M.
Jermit. Pages 1 end 2 sho.
Depertment of Health Important: if iterany injury or
any injury or 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara Chenault(Aunt) 1938 Drew St. Annapolis, Md. 21401 20b. Place of Disposition (Name of H1 Lehn Gas & State of New Color) a 1 Date 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Park 3-20-06 Annapolis, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wm. Reese & Sons Mortuary, P.A. Lavry Neese Moo483 821 West St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical mmunodeficiency syndroms Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last this certificate has been signed by the attending physicien and ral director, page 2 should be detached for use as the burial-transit Exami Due to (or as a consequence of) P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Be Completed by 1 ☐ Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 2 No 1 Tyes Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 25 No 150 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. tnjury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 24 hours a Hospitei **Contriving Physician: To the best of my knowledge death occurred at the time, date and clade and die to the cause(s) and manner as stated:

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 20n Certifier within 24 hor To the Fune completely fi (Check only one) ths 29b. Signature and (title o) certifie 29d. Date signed (Month, Day, Year)

Registrar

State

OF

31. Date filed (Month, Day, Year) 32. Highstrar's Signature

30. Name and address of person who completed cause of death (ttem 23a) (Type,

Signature Land

Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene O. C.

		•	For State of Maryland / Depar State Registrar Cert.	ificate of Death	vientai mygie Reg.	6000	08093
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	March 1	4c. County of Death	1243 A M
	Examin	er	University of Meryland Medical Center	Baltimore		N/A	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth	nplace (State or Foreign intry)
1	Director		213-44-9183				RGINIA
	yland		10a. State 10b. County 10c. City, Town or Local	ition			10d. Inside City Limits
	Se-f e	Director		RE DE GRACE			1 ☐ Yes 2 🖔 🔏 o
	with the	Dire	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Cou	intry?
	death ms 23	Funerai	991 BERN DRIVE APT 1C 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S.	21078 as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	U.S.A. 14. Race - Amer	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "natural; or items 23a or 28e-f ehow any injury or other traumatic event, the Medical Examinar must be notified at once.	by	1 Never Married 2 Married 1 Yes 2 No	Yes, specify Cuban, Mexican, Puerto □Yes 2⊠No <i>Specify:</i>	o Hican, etc.)	Specify: BI	
2-0	72 ho "natur	Completed	(Specify only highest grade completed) (Give ki	nt's Usual Occupation nd of work done during most of work	king 161	b. Kind of Business/I	ndustry
121	within ene. then	jumo	Elementary/Secondary (0-12) College (1-4or 5+)	ONOT use retired) TIST		N/A	
1 2 2	be filed ital Hygie d other event, the	Be Co	17. Father's Name (First, Middle, Last)		ne (First, Middle, Mai		
ylar	should be and Menta smarked umatic ev	To B	STERLIN THOMPSON	IA MOSES			
Maryland	2 sho	1 3		ral Route Number, C			
	1 and Health tem 27 other tr		20a Method of Disposition 20b. Place of Disposit	ern Dr., At 1C,		Grace, Mo c. Location · City or 1	
E O	Pages nent of int: If it iry or o		1 \(\Delta\) Burial 2 \(\text{Cremation}\) Cremation 3 \(\text{Hemoval from State}\)	atory or other place) C CEMETERY 03-	18-06 CI	HURCHVII.I.E	MARYLAND
Baltimore,	permit. Departm Importe any inju		21. Signature of Funeral Service Licensee 22. WM	Name and Address of Facility C BROWN COMMUNI' 1 S PHILADELPHIA	TY FUNERAL	L HOME-HAF	RFORD, P.A.
- 4			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.				Approximate Interval Between
120	Physician		Immediate Cause (Final disease or condition resulting in death) a. //on-Sm4(() C6	ell lung cana			Onset and Death
	/Medical Examiner		Due to (or as a consequence of):)			
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	acuted ind transit	Examiner	triat initiated events C.				
60,	be exe		resulting in death) Last Due to (or as a consequence of):				
68760,	tificate be executed ig physician and as the burial-transit	ledicai	d				
P.O. Box	The law requires that the death cert tite has been signed by the attending bage 2 should be detached for use a	Physician/M	## FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Etal death 3 Etal death 5 0 0 0 0 0 0 0 0 0		23d. Date of deli- Month	very Day Year	
	uires that signed b Id be deta	Completed by Pl	Part II. Dther significant conditions contributing to death but not resulting in the und	lerlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Vital Records,	s beer s beer s shou	ojete	Dialetes		24a. Was an	24b. Were au	topsy findings available
R	The i	Com			autopsy performer	d2 death?	ompletion of cause of 2 No
Vita	Physician: r this certific ral director.	Be	25. Was case referred to medical examiner?		th (Check only one)		
	Phys r this aral dir	i: To	27. Manner of Death 28a. Date of Injury 28b. Time of	3 DOA Other: 4 Nursing H	ome 5 Residence 28d. Describe how		ufy)
ion	Attending r death. ector: After by the fune	atior	1 ☑ Natural 5 ☐ Pending (Month, Öay Year) fnjury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division of	al or Atte s after de il Directo ed in by th	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	nt, factory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death of the best of examination and/or investance and manner stated.	occurred at the time, date and place stigation, in my opinion, death occu	, and due to the caus rred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the comp	M	29b. Signature and title of estiflier	29c. License number	29d	. Date signed (Month	, Day, Year)
•				P17667	1	12Rh 14	2006
			30, Name and address of person who completed cause of death (Item 23a) (Type, P. Y.X.H.Z) INJUC. 22 Suth Greene Street	et, Baltimore,	UD 20	01	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	the s			
3.00	Registr	ar	MAR 1 6 2006	The state of the s			

			For State Registrar	State of Ma	ryland / Der <i>Ce</i>	artment e <i>rtificate</i>	of He	ealth ar Death	nd Me		giene Reg. No.	06	08094
	Physici		Decedent's Name (First, Middle, Last, Bobbie)	Burnett		Teal		2	2. Date of Dea Month 3	ath 12 ^{Day}	2006 Year	3. Time of Death 3:15p M
	/Medio Examir		4a. Facility Name (If not institution, give 936 Stoddard Ct				own, or l	ocation of I	Death		4c. C	County of Death	
	Funeral Director		5. Social Security Number 6. Security Number 238–82–7189 Usual Residence of Decedent	X 7. Age	(In yrs. last birthda Yrs.	() If Under 1 Months	Days	If Under 24 Hours	Hrs. 8 Min.	Date of Birt (Month, Da 6-26	h y, Year) -48	9. Birth Cou	place (State or Foreign intry) N.C.
	Maryland 9-f ehow illed at	tor	10a. State 10b. County Md. N	A	10c. City, Town or Ba.	Location Ltimore)						10d. Inside City Limits 1 Yes 2 No
	vith the	Director	10e. Street and Number	-		10f. Zip (10g. Citize	en of What Cou	•
980	s 1 end 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23e or 28e-f show other traumatic event, the Medical Examinationals be reviilled at	by Funeral	936 Stoddard Ct 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	ever in U.S. 13	. Was Decede If Yes, specif		panic Origir , Mexican, I	n? (Speci Puerto Ri	fy Yes or No- can, etc.)		USA 4. Race - Amer Black, White Specify: B1	ican Indian,
21215-0036		Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12th grade	cation e <i>completed)</i> College (1-4or 5-	(Giv	edent's Usual re kind of work DO NOT use	Occupat done du retired)	tion uring most o	of working	7	16b. Kind of Business/Industry Bethlehem Steel		
	be filed tal Hygi d other	Be	17. Father's Name (First, Middle, Last)		· · · · · · · · · · · · · · · · · · ·	LUCE				First, Middle,		Sumame)	
Maryland	2 should be to and Mental I is marked or raumatic eve	၉	Johnny 19a. Informant's Name/Relationship (T)	rpe, Print)	McNeal 19b. Ma	ling Address ((Street ar		een or Rural F	Route Numbe	er, City or	Hardy Town, State, Zi	
	1 end 2 : Health ar tem 27 ie		Jerry Anthony Tea	l Husb		Stodda		Ct., E		-		21201	
altimore,	ages 1 ent of Heant: If item y or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify)	Removal from State	20b. Place of Dis cemetery, co	ematory or oth	her place		Dai -16-			timore,	
Baltir	permit. Pages 1 Department of H Important: If its any injury or ot		21. Signature of Funeral Service Licens			22. Name and	Address			Bal	timo		21202
8760,	Physician /Medical Examiner with pricial stransit pri stransit pricial str	edicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence of): a consequence of):	EA							Onset and Death
P.O. Box 68	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rall director, page 2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 ☐ Fetal death 3	☐Ectopic pre ☐ Other (spe					23	3d. Date of deliving Month	very Day Year
	uires that signed b id be deta	ρ	Part II. Dther significant conditions co	ntributing to death bu	t not resulting in the	underlying ca	use giver	n in Part I.		23e. Did to			the cause of death?
Vital Records,	itcian: The law require certificate has been sid rector, page 2 shoutd t	Completed										24b. Were aut prior to death? 1 \(\text{Yes}	opsy findings available ompletion of cause of
Division of Vita	ding h. After fune	Certification: To Be	25. Was case referred to medical examiner? 1	1 ☐ Inpatier 28a. Date of Injur (Month, Day	y 28b. Time Year) Injury	of 28	Other Sc. Injury Work 1 Y	4 Nurs	ing Home	d. Describe h	dence 6		
Divi	after Dire	Certifi	4 Homicide determined	building, etc						City or Tox	vn, State)		ral Route Number,
	To the Hospita within 24 hours To the Funeral completely filled	edical	29a. Certifier Check only one)	sician: To the best of ner: On the basis of and manner sta	examination and/or	ath occurred a investigation, i	it the time in my opi	e, date and nion, death	place, an occurred	d due to the	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier				License		0.		29d. Date	signed (Month	, Day, Year)
ŧ.	n-		30. Name and address of person who co	ompleted cause of de	eath (Item 23a) (Typ		700	577	- 2		5	1126	06
	9 Sta	ite	31. Date filed (Month, Day, Year)	05E1-B	o ATWis	10	1	12 4	MSE	ST	BA	MINNEX	2 100 2100
	Registi		MAR 1 6 2006		St Py	_							

			1 - For State Registrar	State of Maryl		artmen rtificate					iene	6	080	95
	Physici		Decedent's Name (First, Middle, Last) Samuel Tilles							Date of Deat Month	Day _	Year 2006	3. Time of	^
	/Medic Examir		4a. Facility Name (If not institution, give st	reet and number)	mert	4b. City,	Town, or	Location o			4c. County		1	
	Funeral Director		5. Social Security Number 6. Sex 218−18−4910 1№		yrs. last birthday) Yrs.	If Under Months	1 Year Days	If Under a		Date of Birth (Month, Day, ct 27,		9. Birthpi Coun	lace (State or try)	r Foreign unk
	ryland thow		Usual Residence of Decedent 10a. State 10b. County	10c.	. City, Town or Lo	ocation						11	0d. Inside Cit	•
	ith the Marylar or 28a-f show	Director	MD 10e. Street and Number		Baltin	nore	Code			10	Og. Citizen of	What Coun	try? Yes	2 No
	th with	ai Di	5715 Park Heights	Avenue #30	5			21215	5		U	SA		
920	72 hours after death w "natural", or Itams 23a	by Funerai	11. Marital Status 1: 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	n U.S. 13.	Was Deced If Yes, spec 1 ☐ Yes 2		spanic Orig n, Mexican Specify:	gin? (Specif i, Puerto Ric	y Yes or No- an, etc.)	Bla	ce - Americ ck, White, fy: whi	etc.	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event. It is Medical Event art must be motified at	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12) unk unl	College (1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us	k done a	uring most	t of working	unk	16b. Kind of B	lusiness/Inc	dustry	unk
Maryland 2	2 should be filed withir and Mental Hygiene. Is markad other than aumetic evant, the M	To Be Co	17. Father's Name (First, Middle, Last)		er's Name <i>(F</i>	First, Middle, N	faiden Sumar	ne)		unk				
Man	12 sho h and l 7 Is me traume		19a. Informant's Name/Relationship (Typ	ə, Print)		-	•			loute Number,				
Baltimore, I	0 0		Sinai Hospital 20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation	Date	e Balti	LMOTE,		21215 wn, State						
Baltii	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Sovice Licenses	ade Vivect	oard 6 21201	655 W.	baltim	ore S	treet					
	Physician /Medical		23a. Pan 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.	leath. Do not en	ter the mode	e of dying	g, such as			est,		Approximate Interval Bety Onset and D	veen
8760,	Examiner	icai Examiner	Sequentially list conditions, and any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of):	CW	LI	r syn i	a ob	Y60	don		1 ohy	<i>y</i> :
P.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pre 1 Live birth 2 4 Pregnant at time 9 Unknown	etal death 3	Ectopic pre						23d. Date of delivery Month Day Ye		
	v requires that been signed b should be deta	ρ	Part II. Other significant conditions cont		resulting in the u 心 こ	nderlying ca	ause give	n in Part I.		23e. Did tob	acco use con		e cause of di	
Vital Records,		Completed	,		24a. Was ar autops perform 1 ☐ Yes	y ned?	Were autor prior to cor death? 1 Yes	osy findings a npletion of ca 2 No	vailable use of					
Vita	P hyaician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	spital: 1 patient	2 🗌 ER/Outpatier	nt 3 DO	Othe			Check only on				
of	ding After fune	ation: To	1 Yes 2 No 1027. Manner of Death 1 Natural 5 Pending 2 Accident investigation	5 Reside			")							
Division	To the Hospital or Attanding within 24 hours after death. To the Funaral Director: After completely filled in by the fune.	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28f	Location (Sti City or Town	reet and Numl , State)	ber or Rura	l Route Numl	2⊖ <i>r</i> ,					
	To the Hospital or A within 24 hours after To the Funaral Directompletely filled in by	edicai	(Check only 2 Medical Examinations)	cian: To the best of my er: On the basis of exan and manner stated.	knowledge, deat nination and/or in	vestigation,	in my op	inion, deat	d place, and th occurred	at the time, da	ite and place,	and due to	the cause(s)	
)	To T Com	Σ	29b. Signature and title of certifier	esuty	$\overline{}$		License	624	1776	3	Date signe	. 4	200 (0
			30. Name and address of person who con	pleted cause of death (Item 23a) (Type,	11	0.1	ei l	nf 1	3alfri	nore			
	Sta		31. Date filed (Month, Đay, Year)	32. Registrar's Si	ignature	ask b	9		00	2.00(11				
	Registi	ar	MAR 1 6 20	06 Alexan	JJ /4	A STATE OF THE PARTY OF THE PAR								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygieria 1 1 6

			1 - For State Registrar	State of Marylar		artment of r <i>tificate of</i>			Jiene 6	00096	
	Discortant	r_{\pm}^{L}	Decedent's Name (First, Middle, Last)	·				2. Date of Dea	th	3. Time of Death	
	Physici /Medio		Gilbert	Luther	-	Tracy		March	9, Day 2006 Ye		
	Examin	er	4a. Facility Name (If not institution, give si Southern Maryland			4b. City, Town, o	or Location of Death		4c. County of Death Prince George's		
H	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign Country)	
	Director		009-10-9362 A	M 2□F 82	Yrs.	Months Days	Hours Min.	Dec. 10		ermont	
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits	
	a-feh	tor	Maryland Prince Ge	eorge's	Cli:	nton				1 ☐ Yes 24 No	
	th with the 23a or 28 at be not	Funeral Directo	10e. Street and Number 9316 Pine View La	ane		10f. Zip Code 2	0735	1	Og. Citizen of What	Country? J.S.A	
-0030	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itema 23a or 28a-f ehow any highry or other traumatic event, Ite Medical Examinational by netitied at ODGe.	by Funer	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced	If You Give	944+ '	Was Decedent of I f Yes, specify Cub I ☐ Yes 2☐ No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. White	
Ž	72 hou		15. Decedent's Educ (Specify only highest grade	ation	16a. Deced	lent's Usual Occup	pation	100	16b. Kind of Busine	ess/Industry	
Ž	ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of work d)		US Navy F	Potirod	
7 0	Hygiel Hygiel thertl	CO	12. Father's Name (First, Middle, Last)	2 1/2		ommander	18. Mother's Name			(etired	
alla	fental rked o	To Be	Luther	Tracy			Rosa		nown)		
Mary	nd 2 shousith and N 27 is mai		19a. Informant's Name/Relationship (Type Agnes Tracy (Wife	al Route Number Clinton,	, City or Town, Stat Maryland	re, <i>Zip Cod</i> e) 1 20735					
ore,	es 1 e of Hee f Itam r othe		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Re	20b. F	Place of Disponentery, cren	sition (Name of natory or other pla	ce) Marc	Pate 22,	20c. Location - City	or Town, State	
Saltimo	tment tant: t		4 □ Donation 5 □ Other (Specify)			n, Virginia					
מ	Dermii Depar Impor any Ir		21. Signature of Funeral Service License	le 10019	_] _		ess of Facility Leo Alexandria			n, MD 20735	
a	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Postal	-n/	fresh fresh	ng, such as cardiac	or respiratory arm	est,	Approximate Interval Between Onset and Death	
	Examiner		- 1	Due to (or as a consec	quence of):	-					
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	ence of	0	1				
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a donseo	rance of: I	Jan	Ore-	_			
٥	ificate be executed g physician and as the burial-transit			<1 p	1	1-1					
000	tificate ng phy as the	Aedical	u.		mon	fit or					
O. DOX	To the Hospital or Attending Physician: The law requires their the death cert within 24 hours after death. To the Funeral bifrection: After this cartificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	al death 3	Ectopic pregnanc Other (specify)	у		23d. Date of Month	delivery Day Year	
Ļ	s thet gned by	by Ph	Part II. Other significant conditions cont	ributing to death but not res	sulting in the ur	nderlying cause giv	en in Part I.	23e. Did tol	bacco use contribut	e to the cause of death?	
ecorus,	require sen sig	ted						1 🗆 Ye	es 2□No 3□	Probably 4 X Unknown	
פרו	The law ate has by page 2 sh	Completed			<u> </u>			24a. Was a autops perform	y prior med? deat	e autopsy findings available to completion of cause of n? res 2 \sum No	
<u> </u>	ician: certific rector,	Be	25. Was case referred to medical examiner?	espital:	V	Ott	26. Place of Death				
5	Phys er this eral di	n: To	1 ☐ Yes 2 ☒ No	28a. Date of Injury (Month, Day Year)	XER/Outpatien 28b. Time of	28c. Injui	4 Li Huising Ho		ence 6 Other (5	Specify)	
NISIOIS I	ath. rath. rr: Afte	atlo	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		rk? Yes 2 □ No				
	al or Atte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, stre	eet, factory, office		28f. Location (St City or Town		r Rural Route Number,	
	ne Hospit n 24 hour ne Funera	Medical (29a. Certifier (Check only one) 1 Certifying Physical Certifical Certi	cian: To the best of my kno er: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the til restigation, in my o	me, date and place, ppinion, death occurr	and due to the cared at the time, d	ause(s) and manne ate and place, and	r as stated. due to the cause(s)	
	Withii To th	ž	29b. Signature and title of certifier)_		29c. Licens		2	9d. Date signed (M	onth, Day, Year)	
			my.				4535		03,09	,06	
	18		30. Name and address of person who con Laxmi Berwa, MD 7	npleted cause of death (Iter 700 Old Brand	n 23a) (Type, I ch Aven	ue Suite	101 Clin	ton, MD	20735		
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature /	uk)					
	Registr	ar	MAR 1 6 2006	Als care A	S. Marie						

			For State of Marylan - State Registrer	d / Depa <i>Cei</i>	artment of H rtificate of L	ealth and Death		ene 0 06	08097		
~			1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death		
	Physici /Medic		TAYLOR JUNIOR VANMETER					Day Year 7TH, 2006			
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Deat		4c. County of Death			
			MEMORIAL HOSPITAL		CUMBERLAI	ND		ALLEGANY			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. 1	***	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birth	(ear) 9. Bi	nthplace (State or Foreign		
	Director		216-22-5665 XXM 2□ F 79	Yrs.			Aug 19,	1926 Wes	st Virginia		
	and *		Usual Residence of Decedent 10a, State 10b. County 10c. City	y, Town or Lo	cation				10d. Inside City Limits		
	daryl f sho	ъ	MD 411	01.1-					1 ☐ Yes 2 ☑ No		
	the t	Director	MD Allegany 10e. Street and Number	01dt	10f. Zip Code		100	g. Citizen of What C			
	death with the Maryland me 23a or 28a-f show crivet be actified at		14201 Old Oldtown Road SE		10.1.4	21555		USA	, .		
	ne 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.	S. 13. V	Was Decedent of Hi f Yes, specify Cuba		Specify Yes or No-	14. Race - Am	erican Indian,		
215-0036	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other then "naturel", or Iteme 23a or 28a-f show event, Its Madical Examinar must be notified at	by Fun	Amed Forces? 1 □ Never Married 2 ☑ Married 1 □ Never Married 2 ☑ Married 1 □ Yes, Give Year or Dates: 144		f Yes, specify Cubai 1 □ Yes 2∑∑ No	n, Mexican, Puèr Specify:	to Rican, etc.)	Black, Wh	ite, etc. white		
Ž	2 hou	ted	15. Decedent's Education	16a, Deced	ient's Usual Occupa	ition	16	6b. Kind of Busines	s/Industry unk		
25	within 72 ene. then "na	Completed	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+)	(Give life. L	kind of work done of DO NOT use retired,	luring most of wa)	rking				
7	d witl giene grthe	mo;	8 0	1ab	orer						
<u> </u>	be filed tal Hygie d other event, II	ВеС	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle, Ma	iden Sumame)			
/land	should be nd Mental marked o	To	Issac Taylor Van Meter			Elma	Grapes				
Mar	ss 1 and 2 should b of Health and Menti Item 27 is marked r other traumatic		19a. Informant's Name/Relationship (Type, Print)				ural Route Number,				
_	and 2		Lena Van Meter/spouse	1420	01 01d 01d	ltown Ro	ad SE 01dt	own, MD	21555		
altimore,	permit. Pages 1 a Department of He Important: If Item any Injury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify)	tace of Dispo emetery, cren	sition (Name of natory or other place	9)	Date 20	c. Location - City o	r Town, State		
Dall	permit. Departr Importa any Inji		21. Signature of Euroral Services icensee Ronald 8. Wade licector	St Ba	Name and Address ate Anato ltimore,	s of Facility my Board MD 2120	d 655 W. E	altimore	Street		
			23a. Part1. Errer the disease, or complications that caused the death					t,	Approximate Interval Between		
	Physician		shock, or heart failure. List only one cause on each line.	Λ . Δ	n. 1				Onset and Death		
	/Medical		disease or condition resulting in death) a. Drong Due to (or as a consequence)	ineuce of).	ien Di	sease	<u> </u>		D years		
	Examiner			30.100 0.,.							
		ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence)	uence of).							
	icate be executed physicien end s the burial-transit	Examiner	of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
o Î	exec en en rial-tr		resulting in death) Last Due to (or as a consequ	uence of):							
00/8	ysicio	dicai	d.								
0	certificate be executed nding physicien end use as the burlat-transit	Ved									
ă	wrequires that the death certifi been signed by the atlending p should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ↓ □ Var 2 □ Var 4 □ Pregnant at time of december 2.	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year		
j	the d	ysi	1 Yes 2 No 4 Pregnant at time of de 9 Unknown	Jan 3 _	Other (specify)						
7	that ed by deta	4	Part II. Other significant conditions contributing to death but not resu	ulting in the ur	nderlying cause give	n in Part I.	23e. Did toba	cco use contribute t	to the cause of death?		
ecords	requires that een signed bi nould be deta	d by					1 ☐ Yes	2 □ No 3 □ P	robably 4 Unknown		
ក្ល	law rec as bee 2 shou	Completed					24a. Was an	24b. Were a	utonsy findings available		
e L	0 - 0	Ĕ					autopsy performe	id?_ death?	utopsy findings available completion of cause of		
NI S	iician: Th certificate rector, pag	ပ္	25. Was case referred to medical			26 Diago of Do		No 1 □ Ye	s 2 No		
	Physician: this certific ral director,	To B	examiner? Hospital:	ER/Outpatien	t 3 DOA Othe	r	ath <i>(Check only one)</i> Home 5 ☐ Residen	no 6 Mother (Co.	an ful		
ō	y Phys or this oral di		27. Manner of Death 28a. Date of Injury	28b. Time of	28c. Injury Work		28d. Describe how		ecity)		
<u> </u>	After	흝	1 ⊠Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury		? ′es 2 ☐ No					
UNISION	Attended of the by the	₩	3 Suicide 6 Could not be 28e. Place of Injury ⋅ At ho	me, farm, stre	eet, factory, office		281 Location (Stre	et and Number or F	Rural Route Number,		
5	al or	Certification;	4 Homicide determined building, etc. (Specify	<i>'</i>)			City or Town,	State)			
	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	edical (29a. Certifier (Check only) 2 Medical examiner: On the basis of examinat	wledge, death	occurred at the tim	e, date and place	e, and due to the cau	se(s) and manner a	as stated.		
	the F	led	one) and manner stated.								
	5 × 5 × 5 × 5 × 5 × 5 × 5 × 5 × 5 × 5 ×	Σ	29b. Signature and title of certifier		29c. License	number		I. Date signed (Mon			
		5 3	// En/		D3	36766	1	lanen	7,2006		
			30. Name and address of person who completed cause of death (Item	23a) (Type,	Print)						
			POONAI, VIKRAMADITYA, M.D., 924	SETON	DRIVE, C	CUMBERLA	ND, MD 21	502			
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signal MAR 1 6 2006	ture	market &						
	Registr	ar	MAR 1 6 2006 Mayor .	42. Est							

VOID

CERTIFICATE

2006-08098

SEE

CERTIFICATE #

2005-43897

			1 - For State Registrar	State of Ma		epartment of H Certificate of I		nental Hygiei Reg.	4000	08099				
	Physici		Decedent's Name (First, Middle Ray Lee !	Last) Zimmerman				2. Date of Death Month March 14	Day 2006	3. Time of Death 6:30A M				
1	/Medic Examin		4a. Facility Name (If not institution,			4b. City, Town, or	Location of Death		4c. County of Dea					
ĺ	Zami		3721 Sy1va	n Dr.		Lo	cheran		Ba1t:	ltimore				
	Funeral			37.37	(In yrs. last birth	day) tf Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye		rthplace (State or Foreign ountry)				
L	Director		184-40-0370	X XM 2□ F	54 Y	rs.	TIOUTS INTIN	Dec. 2, 1	, 1951 Pennsylvania					
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits				
	Aaryli Feho	ō	MD Carr		**	minster				XXYes 2 □ No				
	the ?	Director	10e. Street and Number	011	West	10f. Zip Code		100	Citizen of What C	ountry?				
	3a or	io i	64R W.Main	St.		2115	7		U.S.A.					
	death ma 2	nera	11. Marital Status	12. Was Decedent Ev	ver in U.S.	13. Was Decedent of H tf Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-	14. Race - Am					
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nd Mentel Hygjene. marked other than "naturel", or itema 23a or 28a-f show imatic event, it a Medical Evanthar marke couling a	by Funerai	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed XXDivorced	Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates:		1 ☐ Yes XX No	Specify:	Hican, etc.)	Specify: W					
2	72 ho	Completed	15. Decedent' (Specify only highest	s Education	16a. [Decedent's Usual Occup Give kind of work done of life. DO NOT use retired	ation	ing 16b	. Kind of Business	s/Industry				
2	ithin ser.	npi	Elementary/Secondary (0-12)	College (1-4or 5+	,)		_	•				
2	led w lygier her th	Co	12			Painter	40 Mark (N)		own Bus	iness				
anc	m 0 =	Be	17. Father's Name (First, Middle, L Walter Zin		e (First, Middle, Maid .known	ien Sumame)								
Ë	hould d Me mark matic	2	19a. Informant's Name/Relationsh		al Route Number, Cit	h, or Tours Ctate	Zio Codol							
S	nd 2 s lth an 27 is		Tammy Hale /				, MD 21136							
5	f Healten		20a. Method of Disposition			Disposition (Name of crematory or other place			Location - City or	·				
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Mente Important: If Item 27 is marked any Injury or other traumatic ex		1 ☐ Burial XXCremation 4 ☐ Donation 5/1 Other (Sp		-	crematory or other place Crematory		/18/05	Baltime	ore. MD				
ä	mit. partm sorta / inju		21. Signature of Juneral Sprice L			hapel P.A.								
m	28 = 3		pichael	punn						11s,MD2111				
П			23a. Part1. Enter the disease, or a shock, or heart failure. List of	complications that caused the	ne death. Do no	t enter the mode of dyin	g, such as cardiac	or respiratory arrest,		Approximate Interval Between				
4	Physician		Immediate Cause (Final disease or condition resulting in death) a. Cardiac Areest											
	/Medical Examiner		resulting in death)	Due to (or as a):								
	LAdminer	_	Sequentially list conditions,	Lung Ca	ncer consequence of					39 Mo				
	ted	Examiner	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury	Date to (01 45 ft)	consequence of	F								
,	execunand and all-tra	Exal	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):								
68760,	ficate be executed physicien and is the burial-transit	edicai		d										
_	tifical ng ph as th		le earlie						T					
ŏ	eath certifi ettending for use as	an/h	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2		3 □Ectopic pregnancy			23d. Date of de					
P.O. Box	at the dea by the et	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tir 9□Unknown		5 ☐ Other (specify)			Month	Day Year				
	hat the d by detact	Phy	Part II. Dther significant condition	TE contributing to death but	not resulting in t	be underhier course and	on in Bort I	230 Did tobacc	o uno contributo t	o the cause of death?				
Vital Records,	The law requires that the death certificate be executed to has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	ted by	Tarris Strong algument condition	- Contributing to death but		ne underlying cause give	en in Pail I.			robably 4 Unknown				
Jec	has be	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of				
g			25. Was case referred to medical					performed 1 ☐ Yes 2 🖸	No 1 ☐ Yes	s 2□ No				
	ysician: is certific director,	o Be	examiner?	Hospital:	2 □ CR(Oute	atient 3 DOA Othe		h (Check only one)	e X 1011-1 (C-1	ecityEx Spouse				
ō	g Phy er thi	n:	27. Manner of Death	28a. Date of Injury	28b. Tir	ne of 28c. Injury		28d. Describe how in		эспурел эройзе				
Ö	ttending F death. ctor: After y the funera	atlo	tX□Natural 5 □ Pending 2 □ Accident investiga		rea <i>r)</i> Inj		Yes 2 □No							
Division of	of or Attend after death Diractor: /	Certification:	3 Suicide 6 Could no 4 Homicide determin		/ - At home, farm (Specify)	n, street, factory, office		28f. Location (Street City or Town, St	and Number or R	ural Route Number,				
	Hospitel or Attending Physician: 24 hours atter death. Funerel Director: Afler this certific lely filled in by the funeral director.													
	To the Hospitet or At within 24 hours after of To the Funerel Direct completely filled in by	Medical	29a. Certifier A Certifying (Check only 2 Medical Pone)	Hysician: To the best of xaminer: On the basis of e and manner state	xamination and/	death occurred at the tim or investigation, in my op	ne, date and place, pinion, death occur	and due to the cause red at the time, date :	e(s) and manner a and place, and du	s stated. e to the cause(s)				
	To the within To the comp	M	29b. Signature and title of certifler	,	· · · · · · · · · · · · · · · · · · ·	29c. License			Date signed (Mon	th, Day, Year)				
			1///			D0055	065	03	-14-2006					
			30. Name sor a towns of person w					man, M.D.						
				h Greene Stre		8, Baltimor	'e MD 212	01		- N				
À	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 6	32. Registrar'	E.o.	Sanath &								
	3		III T U	EUUU MERENAK	JE7" ,	Contract Con								

			for State Registrar		Marylaı	nd / Depa	artmen rtificat			and M	lental H	ygiene Reg. No	.UU	6	0810	
	Physici	an	1. Decedent's Name (First, Middle, Rose P. Z	Last) Zimmerman							2. Date of D Month March		3006	Year	3. Time of Deat 14:15 F	
> «	/Medi Examir		4a. Facility Name (If not institution, Prince George	give street and num	•	tal		Town, or	Location o	of Death	raich	4c	. County		rge's	M
	- Funeral			S. Sex		last birthday)	If Under Months	1 Year	if Under:	24 Hrs. Min.	8. Date of B			9. Birthp	lace (State or Fore	eign
-14	Director		579 22 8843 Usuel Residence of Decedent	^{1□M} XX F		80 ^{Yrs.}					July	1, 1	9. Birthplace (State or Foreign Country) Washington DC			
	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-1 ehow ta Medical Examiner must be notified at	ctor	10a. State 10b. County	e George's		ity, Town or Lo								10	0d. Inside City Lim	
	with th	Director	10e. Street and Number				10f. Zip					_	izen of W		•	
	heath v	Funeral	5009 Yorkville	Road 12. Was Dece	dent Ever in U	J.S. 13.1	Was Decer		748	nin? (Sne	acty Vac or N		United States 14. Race - American Indian.			
036	be filed within 72 hours after death with the Marylan tal Hygiene. d other than "natural", or Itema 23e or 28a-1 show event, I'm Medical Examiner must be notified at	by Fun	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	Armed For	ces? 2.∏.No e.XX	ì	If Yes, spec		Specify:	, Puerto	ecify Yes or N Rican, etc.)	Black, White, etc. Specify: White				
9500-6121	in 72 ho n "natur	Completed by	15. Decedent's (Specify only highest	grade completed)		16a. Dece	dent's Usua kind of wo DO NOT us	al Occupa rk done d	tion uring most	of worki	ing	16b. K	b. Kind of Business/Industry			
7 7	79 15 5 5	Somp	Elementary/Secondary (0-12)	College (1-	4or 5+)	Cler		, , , , , , , , , , , , , , , , , , ,				Pe	рсо			
yland		Be	17. Father's Name (First, Middle, La Emidio Pinto	ist)							(First, Middle Marie		*	9)		
Ε.	should nd Mer marke	2	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street a			// Route Numi			State Zin	Codol	
Z Z	D = V =		Daniel B. Walsh		1)	5009	York	vill	e Roa	d, C	Camp Sp	ring	s, MI	207	48	
ore	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other 2006.		20a. Method of Disposition 1∰Burial 2 ☐ Cremation 3		20b. I	Place of Dispo) ^{ate} 2006	1	cation - C			
baitimor	artmer ortant Injury		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lic			Fort					Г				laryland	_
ñ	Deparenti Deparenti Impo any Ir		Jan John	M01461							Funera Road,				20735	
			23a. Part1. Enter the disease, or co	omplications that ca by one cause on ea	used the deat ch line.	th. Do not ente	er the mod	e of dying	, such as o	cardiac o	r respiratory	arrest,	•		Approximate Interval Between Onset and Death	
38	Physician /Medical		Immédiate Cause (Final disease or condition resulting in death)		ras a consec	tastat	ic Li	ver	Cance	r					Chiset and Death	
	Examiner		Sequentially list conditions.	b												
7	ned	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	ras a conseq	uence of):										
Ď	sate be executed physicien and the burial-transit		that initiated events resulting in death) Last	cDue to (o	r as a consec	uence of):										
00/00	cate be physici the bu	dicai		d												
O. DOX	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours attendeath. with the Funner later death. completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes XIXNo 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown									2	23d. Date of delivery Month Day Year			
	s that the		Part II. Other significant conditions	contributing to dea	ith but not res	ulting in the un	derlying ca	use giver	n in Part I.		23e. Did	tobacco u	se contrib	oute to the	cause of death?	
25	equires	ted by									10	Yes 2	Х . Х ю з	□ Proba	bly 4 □Unknov	VΠ
ביים ביים	: The law r cete has be page 2 sh	Completed								_	24a. Was auto perfe		pri de	or to com ath?	sy findings availat pletion of cause o	ile f
X	sicien certifi irector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ Mo	Hospital: WV	patient 2			0	_		(Check only					
5	ng Phy ter this neral d	on; To	27. Manner of Death	28a. Date of		ER/Outpatient 28b. Time of Injury		Bc. Injury Work	4 🗀 Nur:		ne 5 ☐ Res 8d. Describe					
2	ttendii death. tor: Al the fu	catic	1 ☑ A Matural 5 ☐ Pending 2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	ion			М	1 🗆 Y	es 2□N							
2	s after el Direct	Certification;	4 Homicide determine	d 286. Place o	niury - At no g, etc. (Specify	ome, farm, stre y)	et, factory,	office		2	:8f. Location (City or To			or Rural	Route Number,	
	the Hospi in 24 hour he Funeri pletely filk	edical	29a. Certifier 1 Cartifying (Check only one)	Physician: To the baseminer: On the base and manner	is of examina	wledge, death tion and/or inv	occurred a estigation,	it the time in my opi	, date and nion, death	place, a	nd due to the d at the time,	cause(s) date and	and manr place, an	ner as sta d due to t	ted. he cause(s)	
	To t Com	Σ	29b. Signature and title of certifier					License D508				29d. Date	signed (
	10/	-	> Muff fa 30. Name and address of person wh	o completed asses	1D	220\ /Time = 5		סטכת				1.10	ar CII	10,	2000	
	1,2		Sherif A. Hassa	an, M.D.	3001 Ho	spital	Driv	e, C	hever	1y,	MD 2C	785				
	Star Registra		31. Date filed (Month, Day, Year) MAR 1 6	20	gistrar's Signa		M .				-					

DHMH 17 Rev 1/2001

AEM Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06-01834 State of Maryland / Department of Health and Mental Hygien@ Charles Eugene Arbogast = State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician CHARLES E. ARBOGAST 2006 20 March 14 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death aminer Harbor Hospital Baltimore City
Under 1 Year | If Under 24 Hrs n/a 8. Date of Birth (Month, Day, Year) DEC. 19, 1 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Hours 12 M 2□F Months 45 1960 MARYLAND 220-82-4557 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County work the Medical Examiner must be notified at 1 ☐ Yes 2 No MARYLAND ANNE ARUNDEL SEVERN Directo itama 23a or 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 720 OLD DONALDSON AVE. 21144 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) e filed within 72 hours after al Hygiene. other than "natural", or ita 1X Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify. Be Completed by WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CARPENTER CONSTRUCTION permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygies important: if item 27 is marked other it any injury or other traumatic avant, the once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) WILLIAM ARBOGAST VIOLET JOHNS ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) KATHY BARNEY / SISTER 720 OLD DONALDSON AVE., SEVERN, MARYLAND 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition MARCH 18, 1 ☐ Burial 2 ACremation 3 ☐ Removal from State METRO CREMATORY, INC 2006 CATONSVILLE, MARYLAND 4 Donation 5 Other (Specify) RIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 21. Sign ature of Puneral Ser e Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) INNRIES **Physician** MULTIPLE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9□ Unknown 9 I Unknown δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☒Yes 2 ☐ No 24a. Was an autopsy performed? 2 No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No မ 28a. Date of Injury (Month, Day Year) 28c, Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 7:20 P 5 Pending 1 Natural 2 2 PEDESTRIAN STRUCK BY SUV 3/14/06 1 🗌 Yes 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, N.) City or Town, State) 3 🗆 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide SOUTH BOUND RITCHIE HIGHWAY/WEICHAM AVE ROAD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

3

State 31. Date filed (Month, Day, Year)

Mass

32. Registrar's Signature

1 7 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD



OCME

March 15, 2006

111 Penn Street Baltimore, Maryland 21201

Registrar

ADH KENYON ARCHER Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpenditen# 23a, 27, pen/le, g853, 3/30/06 IT State of Maryland / Department of Health and Mental Hygiene 06 - 17741 - For State Registra Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Year **Physician** MARCH 12, 2006 1216/Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FRANKLIN SQUARE HOSPITAL ROSEDALE BALTIMORE Months Days Hours Min. 8. Date of Birth Months Days Hours Min. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X**M 2□ F 216-39-0355 Director Usual Residence of Decedent with the Maryland 10a. State 10d. Inside City Limits Town or Location or iteme 23a or 28a-f ehow the Medical Examiner must be notified a 1 ☐ Yes 2 No by Funeral Director ω 000C 10f. Zip Code 10g. Citizen of What Country? 21040 USA filed within 72 hours after death Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Ever in U.S 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. De NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) other then College (1-4or 5+) Huden Middle, Las Mother's Name (First, Middle Be . Pages 1 and 2 should be fil tment of Health and Mental H tent: If Item 27 Is marked otl 19b. Mailing Address (Street and 19a. Informant's Name/Raati aship (Type, F od of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: if any Injury or once. 5 Other (Specify) 21. Signature of Fune a Service 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death as cardiac or resoiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** Complications of sickle cell anemia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. sate has been signed by tha attending physicien page 2 should be detached for use as the burial Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2□ No 1 Yes 2 ☐ No Yes ours after death.

neral Director: After this certific filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: ို 1 X Yes 2 □ No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 XER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funeral I
completely filled 1_ Certifying Physician: To the best of my knowledge death consumed at the time data and clans, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 1/2001

ramela

31. Date filed (Month, Day, Year)

E. Southall

7 2006

completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

OCME

111 PENN STREET, BALTIMORE, MARYLAND, 21201

MARCH 13, 2006

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** March 12, 2006 2:30 P James John Amerena /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 404 Haverhill Road Joppa If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months XXM 2 T F 87 Director 032-07-7797 28, 1918 Massachusetts Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 404 Haverhill Road or items 23e 21085 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1♥JYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status e filed within 72 hours after de Il Hygiene. other than "natural", or item Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Sales Manager Heavy Equipment other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any July or other traumatic event page. Be (u/k) Amerena Rapheala (u/k) Andreotti 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Lou Amerena, Wife 404 Haverhill Road, Joppa, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State Hilltop Service Corp. 3/14/2006 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) McComas funerally Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. So not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21009 Approximate Intervat Between Onset and Deat Immediate Cause (Final 10mg6 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit CORONA certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical as the tF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 4☐ Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Duknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 MMP HOCYT 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performer GRACTURE RESSION 1□ Yes 2 No To the Hospitel or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 1 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 [] Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29 Signature and title 1 section 29c. License number 29d, Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) EYVANDS 31. Date filed (Month, Day, Year) 32. Registraris Signature State Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of N	/larylan	d / Depa <i>Cei</i>	artmen rtificate	t of H e <i>of L</i>	lealth a Death	and M	ental H	ygie Reg.	42 (2)	08105	-
	Physici	an	1. Decedent's Name (First, Middle, L.	ast)		_					2. Date of D Month		Day Year	3. Time of Death	1
	/Medic	al	JOHN G. BARLOCK					* .	1		MARCH	14,	2006	6:45 P	M
46°0	Examin	er	4a. Facility Name (If not institution, git 7548 OLD TELEGRA			26			Location o	or Death			4c. County of Death) Er	
	Funeral		Social Security Number 6.	Sex 7.7		iast birthday)	If Under Months	1 Year	If Under 2	24 Hrs. Min.	8. Date of E	Birth	ANNE ARUNI 9. Birthy	olace (State or Fore	ign
die de	Director		379-09-6948	1⊠M 2□F	92	Yrs.	WOTHERS	Days	Hours		JAN. 2		1914 MICH		
	and ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Lim	its
	Mary Be-f sh	tor	MARYLAND ANNE AR	UNDEL	HAN	IOVER								1 ☐ Yes 2 🔀 i	No
	hours after death with the Maryland turel; or Items 23a or 28a-f show al Examirer must be notified at	Directo	10e. Street and Number				10f. Zip					10g.	Citizen of What Cou	ntry?	
	s 23a	eral	7548 OLD TELEGRAP			2 112	210			10/0			ITED STATE		
	fter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Deceder Armed Force 1 \(\text{Yes} \) 2	s?	.5. 13.	Yas Deced	of Hi	ispanic Origin, Mexican	gin? (Spei , Puerto P	cify Yes or N Rican, etc.)	10-	14. Race - Ameri Black, White,		
5	hours after death w tural', or Items 23s	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates			1 ☐ Yes 2	2 X No	Specify:				Specify: WHIT	ΓE	
9200-9121		Completed	15. Decedent's E (Specify only highest g	ducation rade completed)		16a. Dece (Give	kind of wor	rk done d	durina most	of working	ng	16b	. Kind of Business/In	dustry	
	within 72 ene. then "nei	ошо	Elementary/Secondary (0-12)	College (1-4o	r5+)	METAL	DO NOT us ERGIS		"			C	OPPER & BE	RASS	
פ	illed with Hygiene. other ther	BeC	17. Father's Name (First, Middle, Las						18. Mothe	r's Name	(First, Midd		den Sumame)	4100	
ylar	C &	To B	JOHN BARLOCK						DORIS	S GOI	RMAN				
Maryland 2	C		19a. Informant's Name/Relationship				_						ity or Town, State, Zip	ŕ	
ď.	1 and 3 Health tam 27 other tra		MICHAEL E. BARLO	CK / SON	20b. P	lace of Dispo	sition (Nan	ne of			BURN ate		MARYLAND Location - City or To		
ē	Pages ent of nt: If It		1 X Burial 2 ☐ Cremation 3 9 4 ☐ Denation 5 ☐ Other (Spec		6	emetery, crer EN HAVI			1111	ARCH 200			LEN BURNIE		AID.
daitimore,	permit. Pages 1 Department of H Important: If Its any Injury or ot		21. Signature of Funeral Service Lice		7.2.						-				עו
<u>n</u>	895 29		- Hatal ON	<u> </u>		2	21 CR	AIN	HWY.,	, S.E	., GL	EN]	E, P.A. BURNIE, MD	21061	
) ()	23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caus y one cause on each	ed the deatl line.	n. Do not ent	1							Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		+1	The	iluc	The The	516	Rase				
	Examiner		1		as a conseq	dence of);									
-	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	is a conseq	uence of):									
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	e a consegui	uence of):	_								
3/60,	ate be executed hysician and the burial-transit	dical E		200 (0) (0)	13 4 0011364	derice or).									
200	tificate ig phys as the	edic		0.											
gox	death certifics e attending ph d for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	ne of pregna		Ectopic pre	egnancy					23d. Date of delive	•	
	0 00 0	ysici	1 Yes 2 No	4□ Pregnant 9□ Unknown		eath 5□	Other (sp	ecity)					Month	Day Year	
J.	The law requires that the de Ite has been signed by the Page 2 should be detached	y Ph	Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying ca	ause give	en in Part I.		23e. Dio	tobac	co use contribute lo t	he cause of death?	
ras,	quires an sign	ed by									1] Yes	2 No 3 Prot	oably 4 Unknow	₩n
Hecord	m 07 OI	Completed									24a. Wa	s an opsy	24b. Were aulo	ppsy findings availal	ole of
_		Соп										formed		mpletion of cause of	
VItal	ysician: The la is certificate ha director, page?	o Be	25. Was case referred to medical examiner?	Hospital:				Othe	VE /		Check only				_
Ö	ding Phys h. After this funeral di	h	1 Yes 2 No 27. Manner of Death	1 ☐ Inpa 28a. Date of In	ijury	ER/Outpatier 28b. Time of		8c. Injury Work	4 Lamour				6 □Other (Specification)	(y)	
	anding sath. or: Aft	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Day rear)	Injury	М		c? Yes 2 □ N	No					
DIVISION	or Atte	Certification:	3 Suicide 6 Could not 4 Homicide determined	289. Place of I	njury - At ho etc. <i>(Specif</i>)	ome, farm, str	eet, factory	, office		2	8f. Location City or T		t and Number or Rura tate)	al Route Number,	
_	Hospital or Attending Physician: A hours after death. Funeral Director: After this certificately filled in by the funeral director.		29a. Certifier 1 Certifying P	hysician: To the her	st of my kno	wledge death	occurred :	at the tim	ne date and	d place a	nd due to th	e calle	e(s) and manner as s	tated	
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Exa	miner: On the basis and manner	of examina	tion and/or in	estigation,	in my op	pinion, deat	th occurre	d at the time	, date	and place, and due to	the cause(s)	
	To the within 2 To the complet	ž	29b. Signature and title of certifier	01	1	\sim	29c		number				Date signed (Month,	Day, Year)	
			1 postart	John	71	リ	1,	134	109				3/15/06		
	10		30. Name and address of person who	completed dause by	i death (Item	23а) Дуре,	-1	112	МТТ	LLERS	T.I.TVS	M	ARYLAND 21	108	
	Sta	te	31. Date filed (Month, Day, Year)		strar's Signa		8	m 11			. ,	y 114	11431117 21	.100	
	Registr	ar	MAR 1 7	2006	2000	M. A.	BALL S								

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#23b,25 pen/E,855.5/26/06 TT State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month **Physician** 13, Nivedita Μ. Bhatt March 2006 21:15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery Holy Cross Hospital 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2X F Yrs. Director 62 March 27,1943 481-72-0677 Gujarat Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or itema 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18 Middlebridge Court 20906 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ZMNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours atter anent of Heatilh and Mental Hygiene. ant: if item 27 is marked other than "naturat", or ite ury or other treumatic event, the Madical Examina 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Asian-Indian þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Electronic Assembler Defense 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Vaikunthrav Joshi Devamati Joshi 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4301 Michener Road Doylestown, Pennsylvania 18901 Gaurang M. Bhatt/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) artment of ortant: if i injury or West Arundel Crematory 3/16/2006 Odenton, Maryland 21. Sign are of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home, & Crematory, P.A. manita 1411 Annapolis Road Odenton, Maryland 21113 thomas 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or rest tratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician FICATION APPROVED BY MEDICAL EXAMINER Interstitial Lung Disease 1 month Due to (or as a consequence of):
therapy /Medical Examiner Docetaxel Texic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last month Due to (or as a consequence of) physicien and the burial-transit The law requires that the death certificate be executed Exam Breast Cancer 7 months Due to (or as a consequence of): Box 68760. Physician/Medical use as ettending p for use as IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐XNo Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the e P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 1 Yes 2 No 3 Probably 4 Unknown Hypertension certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 3€□ No 24a. Was an 3€ No 1 ☐ Yes 2 💢 No Attending Physician: director 25. Was case referred to medical Be 26. Place of Death | Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ě 4 Homicide filled in ŏ within 24 hours at To the Funaral D completely filled in Hospitel 1 🕇 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) MD. D31001 March 14, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 7500 Greenway Center Dr #430 Greenbelt, MD 20770

Turkewitz,

Stuart J. Tur

M.D.

32. Pagištrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** 2006 March 16. 6:00 A SARAH PARKER KOPPELMAN BANKS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County BROADMEAD Cockeysville If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 212 F Director 91 May 27, 1914 Maryland 214<u>-46-9125</u> Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-1 ehow any injury or other traumatic event, the Medical Examiliar round by published at once. 1 ☐ Yes 2 No Director Maryland Baltimore County Cockevsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21030 13801 York Road USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Residence 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Koppelman, Sr. Grace Lawrence Dunderdale Walter **NMN** 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Daughter) 7714 Ruxwood Road, Baltimore, Maryland 21204 Rebecca B. Mowbray 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 3/17/2006 | Baltimore, Maryland 21. Signatur Jo/Funeral Service Usensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. Martin D. Lawson

Martin D. Lawson

MICCREIT—Wiedered Fuller In Time, 1110.

6500 York Road, Baltimore, Maryland

Proximate Interval Between Onset and Death

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 1110.

Proximate Interval Between Onset and Death Immediate Cause (Final NGE Pnysician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregpant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No Vital 25. Was case relerred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Universing Home 5 Residence 6 Other (Specify) 1 Yes 212 No 2 ER/Outpatient 3 DOA Certification; To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Fund completely f (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 31. Date filed (Month, Day, Year) State MAR 1 7 2006 Registrar

			1 - For State Registrar	State of Mary		artment of F		F	Reg. No.		8109
	Physici	an	Decedent's Name (First, Middle, Last) Woodrow Junior Ba	arr				2. Date of Dea Month March		Year 6	3. Time of Death 4:30 A M
	/Medic Examin		4a. Facility Name (If not institution, give st 3050 Sounding Dri	treet and number)		Edo	or Location of Death		4c. County o	of Death arfor	·d
	Funeral Director		5. Social Security Number 232-66-1704 S. W. W. W. W. W. W. W. W. W. W. W. W. W.	M OFF	yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Da Jan. 13	y, Year) 9. Birth Col 3, 1943 West		ce (State or Foreign y) Virginia
	Maryland -f show fled at	tor	10a. State 10b. County Maryland Harford		: City, Town or Lo Edgewo					100	d. Inside City Limits 1 ☐ Yes 2 X No
	ith the or 28a	Oirec	10e. Street and Number			10f. Zip Code			10g. Citizen of W		y?
	s 23a	rall	3050 Sounding Drive		in 11.0	210		acit. Vac as No	US.		n Indian
036	within 72 hours atter death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Medical Examiliar must be notified at	by Funeral Director	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	 Was Decedent Ever Armed Forces? Yes 2 □ No If Yes, Give Year or Dates: 		was Decedent or r If Yes, specify Cub 1 ☐ Yes 2½ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
21215-0036	vithin 72 ho ne. han "natur s Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	DO NOT use retire	during most of work		16b. Kind of Bus		ifacturing
Q 75	filed v Hygie other t		12 17. Father's Name (First, Middle, Last)		Machi	nist	18. Mother's Name				Lacturing
Maryland	ould be Mental arked o	То Ве	Woodrow Roy Barr	line Fortney							
Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Exam. or must be multified at once.		19a. Informant's Name/Relationship (Type Barbara M. Barr / V	ral Route Number, City or Town, State, Zip Code) Agewood, MD 21040							
Baltimore,			20a. Method of Disposition 1 Burial 2 Cremation 3 Re		ity or Town, State						
ţ			' 4 ☐ Donation 5 ☐ Other (Specify)	E			orp. 3-16		Towson,	Maryl	.and
Bal	Depar Impor any in		21. Signatur of Funeral Service License	mge 1	[1	.317 Coke	uneral Housbury Roa	d, Abin	qdon, Ma		
	Pnysician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Kes	spirator	er the mode of dyli	idost	or respiratory ar	rest,	1	Approximate interval Between Onset and Death
	/Medical Examiner	-		Due to (or as a co	ex Cans	ic Res	piratory	Pail	4re		I manth.
14	ate be executed hysician and the burial-transit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	Thehach	ive Cur	of disea	rse	10		,,,
68760,	icate be e physiciar s the buri	icai	d	Severe	447	incaen	nia			- (042.
P.O. Box (that the death certificat ed by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	⊒Ect <i>o</i> pic pregnanc □ Other <i>(specify)</i> _	у		23d. Date Mon	of delivery	y Day Year
Ś	se G e	by	Part II. Other significant conditions con	tributing to death but no	ot resulting in the u	inderlying cause gr	ven in Part I.	23e. Did to	obacco use contri		cause of death?
Record	The ate h page	Completed		 					osy pr rmed? de	rior to comp eath?	sy findings available pletion of cause of
of Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		Ott	26. Place of Deat	10.00			
on of	dis ys	tlon; To	1 Yes 2 XNo 27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	2 ☐ ER/Outpatier 28b. Time o ar) Injury	f 28c. Inju	4 Nursing no	-	dence 6 ⊡Othe now injury occurre		
Division	E Part	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, st Specify)	reet, factory, office		28f. Location (S City or Tov	Street and Numbe vn, State)	ar or Rural I	Route Number,
	24 hours a Funeral etely filled	edicai C		sician: To the best of m ter: On the basis of exa and manner stated.	imination and/or in						
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1		29c. Licen			29d. Date signed		
	[164C		Utom 22 at Trees	-	0184				,2006
	8X'		B.D. PARE	No eted cause of death KH MD.	190	8 Hart	nd Rd	Falls	ton Mo	210	47
	Sta Regist		31. Date filed (Month, Day, Year) MAR 1 7 200	32 Registrar's	Signature 🦽	8482					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 26 per doc 9853 3-17-06 vt
State of Maryland PDepartment of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** Irene, Bogorae 2006 1:15 P March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Washington Hagerstown Village of Robinwood 8. Date of Birth (Month, Day, Year) Oct. 28, 1 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 5. Sex **Funeral** Months 1 ☐ M 2 💢 F Maryland Yrs. 1926 212-20-3574 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat is utilized at once. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 No **Funeral Director** Smithsburg Maryland washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21783 U. S. A. 106 Rebecca's Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ģ White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10th Grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Theresa Lewondowski Stephen Zamenski 7 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 106 Rebecca's Court, Smithsburg, Maryland 21783 Randall Nickels (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Stanislaus Cem. 3/07/2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 3331 Brehms Lane, Baltimore, Maryland 21213 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic lung. 6 months Pnysician Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🐼 No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Chronic obstructive lung disease 1 Yes 2 No 3 Probably 4 Unknown leted Congestive heart 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Compl Hypertension 1 ☐ Yes 2X No Hospital or Attanding Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Assisted

Other (Specializing examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To tha Funeral Director: completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D45563 03-03-2006 adu M. Vheadar

DHMH 17 Rev 1/2001

State Registrar 324 East Antietam Street

32. Registrar's Signature

Hagerstown, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

Kadu M. Theodoru,

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of Marylar		artment rtificate			•	giene Reg. No.	006	08	
			1. Decedent's Name (First, Middle, Last)						2. Date of De			3. Time o	of Death
	hysicia	-	Joseph	John Benny,	Sr.				Month March	Day 20	Year 006	9:15	5 P M
	/Medic xamin		4a. Facility Name (If not institution, give s	street and number)		4b. City, To	wn, or Locati	ion of Death	1102011		county of Death		
•	Admin		Johns Hopkins Bay	zview Medical	ctr.		Baltim	ore C	itv		N/A		
Fu	neral		5. Social Security Number 6. Sex			If Under 1	Year If Un	der 24 Hrs.		h	9. Birth	place (State	or Foreign
	ector		219-10 - 6926	M 2□F 79	Yrs.	Months [Days Hou	rs Min.	May 25	1926	Mary	1and	
D			Usual Residence of Decedent										
rylar	1	_	10a. State 10b. County	:	ty, Town or Lo							10d. Inside C	
e W	1	용	Maryland Baltin	nore			Dundal	K				1 ∐ Yes	s 2. No
ج ج	10 M	Director	10e. Street and Number			10f. Zip C	ode			10g. Citize	on of What Cou	intry?	
£ 8	3		402 Trappe Road			2:	1222			Uni	ted Sta	tes	
r de	Ę	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	l.S. 13.	Was Deceder	nt of Hispanic	Origin? (Space)	ecify Yes or No Rican, etc.)	- 14	Race - Amer Black, White		
9 affe	틸		1 Never Married 2 Married	1 □XYes 2 □ No If Yes, Give		1 □ Yes 20					Specify:	, 5151	
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene.	4	d by	3 Widowed 4 Divorced	Year or Dates: WWI							N	hite	
2 2	disa	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Dece (Give	dent's Usual (kind of work of DO NOT use	Occupation done during r	nost of work	ing	16b. Kind	d of Business/li	ndustry	
Vithin on	N N	m d	Elementary/Secondary (0-12)	College (1-4or 5+)			retired)			_	. ,	1 ~	~
led wi	T T		10 Years 17. Father's Name (First, Middle, Last)		P	ainter	10 14	athada Nam	e (First, Middle,		tinenta	I Can	Corp.
De f	2 2	Be											
arylan should be	Lat C	၉	Artley Benny	D	401 14 15				ne Sunde				
Maryland of 2 should be file th and Mental Hy	recu		19a. Informant's Name/Relationship (Ty)	· ·					al Route Numbe .alk, Ma				
e, K 1 end 3 Health	ther		Mrs. Ruth E. Benn 20a. Method of Disposition					-	Date				
Pages	5 6		1 National 2 ☐ Cremation 3 ☐ R	emoval from State	Place of Dispo cemetery, crei	natory or othe	er place)		Date		ation - City or T		
Baltimore, permit. Pages 1 er Department of Hea	important; it their 27 is marked other them, retures, or them 238 of 288-1 show any injury or other treumstic event, the Medical Examiner must be notified at DDGs.		4 Donation 5 Other (Specify)		k Lawn	-		/17/20	-		timore		land
Separation of the separation o	eny in		21. Signature of Funeral Service License		22 I	. Name and A Ouda – Ru	Address of Fa ICK Full	neral	Home of	Dunc	dalk, I	nc.	
40.	- 0 G		276						ındalk,		and 2		
			23e. Part1. Enter the disease, or compli- shock, or heart failure. List only on	e cause on each line.	n. Do not ent		, .		i i	_		Approximate Interval Bet Onset and	tween
Phys			Immediate Cause (Final disease or condition	CORONA	RY	ART	ERY	DI.	SEASI	<u> </u>		Olise(alid	Dealin
/Me Exan	dical		resulting in death)	Due to (or as a consec	mence of		,						
_ Au		_	Sequentially list conditions,	MIKIAL		32/L	LA7	ION	, 				
8 8	sit	ine in	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec		1.00							
60, 7 & be executed	the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	//¥>	UFA	CIEN	(CY					
8760, ate be ex	ouria			PEPTIL	1011	68	DIC	EAU					
cate o	the	dlcal	_ d	IETHO	ULL	e /	17156	514 56		-			
death certificate	for use as th	Physiclan/Med	IF FEMALE:	Pa If you system as a second									
BOX	or us	an	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1☐Live birth 2☐Feta	il death 3□	Ectopic preg				23	d. Date of delive Month	-	Year
	tached	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of o	leath 5	Other (spec	rty)					,	-
	letac	듄	Part II. Other significant conditions con	tabuting to dooth but got con	udian in the co		i- D	-41	220 Did to		contribute to	Nh	de sub O
ecords, P.O. law requires that the	be det	호	Tatti. Othor organizations con	indiang to obder but not 193	and g in the d	idenying cau	se given in Fe	ait i.		es 2			Uknown
ecords,	should	Completed								63 20		Dably 4 au	
aw a	228	힐							24a. Was autop	an sy	24b. Were auto prior to co	opsy findings ompletion of a	available cause of
F F F	page 2 s	် ပြ								rmed? 25000	death? 1 ☐ Yes	_ /	
VISION OF VITAL Attending Physician: 7 r death.	director, pag	Be	25. Was case referred to medical examiner?				26. P	lace of Deat	h (Check only o	ne)			
Physic Color	2 ਜ਼ਿੱ⊟	၉	1 ☐ Yes 2 ☐ No H		ER/Outpatier			Nursing Ho	me 5 Resid	ience 6 (Other (Speci	fy)	
ם מפיי	funera	ü	27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c	. Injury at Work?		28d. Describe !	now injury	occurred		
ISIO Itendi death.	the fu	ä	2 Accident investigation			М	1 ☐ Yes 2	?□No					
DIVISION I or Attending after death.	yd	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory, o	ffice		28f. Location (S City or Tox	Street and i	Number or Rur	al Route Num	nber.
Ital o	n pe												
To the Hospital or At within 24 hours after d	completely filled	ca	(Check only 2 Medical Examin	ician: To the best of my known of the basis of examination	wledge, death	occurred at	the time, date	and place,	and due to the	cause(s) ar	nd manner as	stated.	s)
To the P within 24	nplet	Medical	Unity .	and manner stated.									
D ¥ C	2 8	-	29b. Signature and title of certifier	1		29c. L	icense numb	er Orac		29d. Date:	signed (Month,	Day, Year)	
•	N.		Samuau U	JUSE 1	10		12%	1188		_>/.	15/06		
\	71,		30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type,	Print) 7	1-	4	in Sall	TA	10	2.00	0 -
1			SALIMAN 11 11	11111 2 M	andle	0 1	111	1)//	10 del	c /	11)	422	-
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	00 44	- /	au.	VW	000				

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other treumatic event, the Medical Examiner must be nutitied at any injury or other treumatic event, the Medical Examiner must be nutitied at any injury or other treumatic event, the Medical Examiner must be nutitied at any injury or other treumatic event.

Completed by Funeral Director

Be

2

Physician

/Medical

Examiner

10a. State

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospitel or Attending Physician: The law requires that the death certificate be executed physicien and the burial-transit Division of Vital Records, P.O. Box 68760, attending ph within 24 hours after death.

To the Funeral Director; A completely filled in by the fu

	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing A	ddress (Street and Number or	r Rural Route Number, City	or Town, State, .	Zip Code)
	James Baker/spouse	5799 но	omestead Stree	et Salisbury.	MD 218	301
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)	20b. Place of Dispositio cemetery, cremato		Date 20c. I	ocation - City or	Town, State
	21. Signature of Funeral Service Licensee Ronal S. Wade hire	ctor Stat	me and Address of Facility ce Anatomy Boa imore, MD 21	ard 655 W. Ba 201	ltimore	Street
	23a. Part1. Enter the disease, or complications that caused t shock, ox heart failure. List only one cause on each line	he death. Do not enter th	e mode of dying, such as car	diac or respiratory arrest,		Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	Car woma	of the Colon			
	Sequentially list conditions	consequence or,	· · · · · · · · · · · · · · · · · · ·			
nlner	if any, leading to immediate ause. Enter Underlying Cause (Disease or injury	consequence of):				
Exan	that initiated events resulting in death) Last C. Due to (or as a	consequence of):				
lcal	d					
Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of de Month	delivery Day Year			
ed by Ph	Part II. Other significant conditions contributing to death but Diaheres multur	t not resulting in the under	lying cause given in Part I.			o the cause of death?
Somplete				24a. Was an autopsy performed⊋ 1 ☐ Yes 2 ☑ N	prior to death?	utopsy findings available completion of cause of s 2 2 No
3e (25. Was case referred to medical		26. Place of	Death (Check only one)		
		t 2 ER/Outpatient	3 DOA Other: 4 Nursir	ng Home 5 Residence	6 ☐Other (Spe	ecify)
atlon: 1	27. Man er of Death 1 Natural 5 Pending (Month, Day) 2 Accident investigation	Year) Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how inj	ury occurred	
Medical Certification: To	3 Suicide 6 Could not be determined 28e. Place of Injun building, etc.	ry - At home, farm, street, (Specify)	factory, office	28f. Location (Street a City or Town, Sta	and Number or F te)	tural Route Number,
dical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of and manner state	examination and/or invest				
Me	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Mon	th, Day, Year)
	WO WO		D54127		3/9/0	6

100 nower

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type

7 2006

Hon DAMS MO

31. Date filed (Month, Day, Year)

MAR 1

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end 1ten 3 per doc 853 3-17-06 vt.
State of Maryland / Department of Health and Mental Hygiene 6 6 6 State Registrar Amend Item #5 Per FH G853 3/30/106 atta of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3:11a Month PHYLLIS BONDMARCH 14 2006 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 10M 20F 04/01/1942 216-38-4761 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County BALTIMORE BALTIMORE 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 24 STIRRUP COURT 21208 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No 1 Never Married 2 Married WHITE 1 Yes 2 No 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LAW PARALEGAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) KLEINMAN SUTTON BETTY MORRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID KLEINMAN / BROTHER 12103 FORT CRAIG DRIVE-WOODBRIDGE, VA. 22192 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State CHIZUK AMUNO CONG. 03/16/2006 BALTIMORE, MD. 4 ☐ Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final LUNG Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery nt 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

MD

Director

Completed by Funeral

Be

၉

Funeral

Director

ō detached filled in by the funeral

Completed

Be 2

Certification;

Medicai

Division of Vital Records, P.O. Box 68760,

Ical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnal in the past 12 months? 1 Yes 2 No 9 Unknown Part II, Other significant co
Ω	Dill

r significant condition	s contributing to	death but not	resulling in the und	erlying cause given in Par	rt I.
PHLEB	ITIS				

9 Unknown

23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No

25	. Was case referre	d to medical		26. Place of Death (Check only one)								
				1 Impatient 2	☐ ER/Outpatient	3□	DOA Other:	4 🗌 Nursing H	Home 5 ☐ Residence 6 ☐ Other (Specify)			
27	. Manner of Death 1 Natural 2 Accident	5 Pending investigation	1	ate of Injury Month, Day Year)	28b. Time of Injury	М	28c. Injury al Work? 1 ☐ Yes		28d. Describe how injury occurred			
	3 ☐ Suicide 4 ☐ Homicide	6 Could not to	280. F	Place of Injury - At I building, etc. (Spec	home, farm, stree ify)	ory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		Y-4										

29a.	Certifier (Check only one)

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

296.	Signa	lure and	titie oi	ceuulei	
		G	I.	a	21

29c. License number 027730 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. CHARLES IT. 10 6569 GARY CONEN

State Registrar

D

31. Date filed (Month, Day, Year) 2006



within 2 To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 6:40 AM **Physician** 9006 6 Dorothy Ciric /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Jan. 16, 1917 Baltimore Hospital runklin. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🔀 F Yrs. 89 Director 397-03-1068 Wisconsin Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 ie marked other than "natural", or iteme 23e or 28e-f ehow other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No Maryland Baltimore Perry Hall Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States
14. Race - American Indian. by Funera 9900 Walther Boulevard 21234 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ₩idowed 4 Divorced Maryland 21215-003 White al Hygiene. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Chemistry Teacher Secondary Education 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental ္ရ Sava Batas Catherine unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 7208 Bellona Avenue, Faltimore, Mi) 21212
Loc of Disposition (Name of Date 20c. Location - City or Town, State Pages 1 and Dr. Thomas M. Zizik, Son Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Depertment of important: If it any injury or o ŏ 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Dulaney Valley Memorial Cons. 3/18/06 Timonium, Maryland 22. Name and Address of Facility Brian T. Chisholm Funeral Services of Dulaney Valley, P.A. 200 Padonia Road, Timonium, MD 21093 M01113 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coratory to Due to (or as a consequence of): **Physician** /Medical Examiner cora Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine sicien and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending physi IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signer should be d þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No s certificete has t tirector, page 2 s 1 Yes 2 ₩ No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1/2 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; 1 (Z Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined

P.O. Box 68760, Records, Division of Vital or Attending Physician: s after death. the filled in by

within 24 hours a To the

0

State Registrar

Medical

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MI 9000

31. Date filed (Month, Day, Year) MAR 1 7 2006

2. Registrar's Signature 11/10/10

tu Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State of Maryland / Department of Health and Mental Hygiene State
Registre Amend item #9 Per FH G854 4/100/006calle of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Yeer **Physician** Myome Thompson Cook March 13:17 10 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMO IZE

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) N/A HOSATAI ST- Manies 9. Birthplace (State or Foreign Visrainia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√2 F Yrs. 75 Director 230-34-7162 Dec. 4,1930 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f ehow the Medical Experiment was be restilled at Chatham 1 ☐ Yes 2 X No Directo Pittsylvania VA 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 572 Gentle Pasture Road United States 24531 filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farming 11 Years Self Employed other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) pormit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Importent: If Item 27 Is marked oth any njury or other traumatic event 2002. Downy Thompson Willie Noel Bryant 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Cook (Husband) 572 Gentle Pasture Road Chatham, VA 24531 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ② Other (Specify)

21. Signature of Fundral Service Licensee ghland Burial Park 3/13/2006 Danville, Va 24540 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** olou months Can /Medical Due to (or as a consequence of) Examiner vation HOUVS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Hears Due to (or as a consequence of) O. Box 68760, ate has been signed by the attending physicien page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Records. P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 KQUnknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 1 Yes 2 No 1 Yes Division of Vital To the Hospital or Attending Physician: After this certification funeral director, I 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 2 patient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: d in by the 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by 4 Homicide Entifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ladi Marood Résident. P-199-22 March-10. 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIHORE, MD, 21229 AUE, 900. S. LATON 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 1 7 2006 Registrar

			1 - For State Registrar	State of	f Marylar		artmen rtificate			and M	lental Hyg	iene	06	08116
			1. Decedent's Name (First, Middle, Las	t)					~		2. Date of Deat Month	h Day	Year	3. Time of Death
	Physici /Medio		Charles Cartwri	.ght									2006	1436 M
	Examir		4a. Facility Name (If not institution, give	street and nun	nber)		4b. City,	Town, or	Location o	f Death		4c. Co	unty of Death	
			MEMORIAL HOSPI	CAL			CUM	BERL	AND			AI	LEGANY	
	Funeral		5. Social Security Number 6. Se 217–28–0040	x XM 2□F	7. Age (<i>In yr</i> s. 75	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	Cour	12
	Director		Usual Residence of Decedent		/3						Sept 29	, 193	0 Mar	yland
	yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						1	0d. Inside City Limits
	Mar	ģ	MD Allegan	ny		Cumber	land							1 ☐ Yes 2√ No
	h the	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen	of What Cour	ntry?
	23a c		519 Dilley Stree	t					2150	02		ī	JSA	
	dea	Funeral	11. Marital Status	12. Was Dece Armed For	dent Ever in U	J.S. 13.1	Was Deced	ent of Hi	ispanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,	
9	or it		1 Never Married 2 Married	1 ☐ Yes If Yes, Giv	2 💢 No		1 ☐ Yes		Specify:	,	110411, 010.7		ecify: whi	
ğ	ural',	d by	3 Widowed 4 Divorced	Year or Da	ites:									
2	within 72 hours atter death with the Maryland ene. than "natural", or iteme 23e or 28e-f ehow ta Mccifcal Exacities could be coulded at	Completed	15. Decedent's Ed (Specify only highest grad			16a. Deced	dent's Usua kind of wor DO NOT us	rk done d	during most	of worki	ng	16b. Kind	of Business/Inc	dustry
2	within and the man	Ē	Elementary/Secondary (0-12)	College (1-	-4or 5+)					_			c 1	
2 2	Hygie Hygie Sther	ပို	17. Father's Name (First, Middle, Last)	<u> </u>			factory worker 18. Mother's Name (First, Middle, Ma						food	
a	ould be Mental arked o	o Be	Charles H. Cartw	right							Eva Ste		,	
<u> </u>	2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. Is marked other than "natural", or iteme 23e or 28e-f show aumatic event, Inc Medical Exactiner mast be retified at	2	19a. Informant's Name/Relationship (7			19b. Mailir	ng Address	(Street a			I Route Number,		wn. State. Zio	Code)
<u> </u>	permit. Pages 1 end 2 should Department of Heelth and Men Importent: If Item 27 ie marke any injury or other traumatic 0000.		Dorothy Cartwri	ght/spo	use		-				ımberlan			_
Baltimore, Maryland 21215-0036	t Hee		20a. Method of Disposition		1 1	Place of Dispo	sition (Nan	ne of	al	0	ate	20c. Location - City or Town, State		
Ē	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ② Donation 5 ☐ Other (Specify		State	oomotory, croi	natory or o	iner praci						
<u>=</u>	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service licen	iloda AD	4/1-	22	. Name an	d Addres	s of Facility	у 1				
m	Depa Impo any i		mont	wade	Treets		late A ltimo	nato re.	omy Bo	oard 21201	655 W.	Balti	imore S	treet
	Physician /Medical Examiner parisition and prize	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of):								est,		Interval Between Onset and Death	
9	cate phy:	dicai	IF FEMALE:	d.								- 1		
O. Box	The lew requires that the death certifi te has been signed by the attending age 2 should be detached tor use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		nth 2 ☐ Feta ant at time of c	al death 3	Ectopic pro Other (spe					23d.	Date of delive Month	ory Day Year
ت. ح	s that ned b	by PI	Part II. Other significant conditions co	ntributing to de	ath but not res	sulting in the u	nderlying ca	ause give	n in Part I.		23e. Did tob	acco use	contribute to th	ne cause of death?
Vital Records,	w requires been signi should be	a pa	Diabetes								1 □ Ye	s 2 □ N	o 3□Prob	ably 4 donknown
ပ္က	lew requias been 2 should	Completed									24a. Was ar	2	4b. Were auto	psy findings available appletion of cause of
ř	The cete has page	Eo									autops perform 1 Yes 2	19g/	death?	
II	iician: Th certiticete rector, pag	Be C	25. Was case referred to medical						26. Place	of Death	(Check only one	-		
<u> </u>	S .5	To	examiner? 1 Yes 2 No	Hospital: 1 ☐ Ir	npatient 2 Z	ER/Outpatien	1 3 DO	A Othe	er: 4 □ Nur	rsing Hor	ne 5 🗆 Reside	nce 6	Other (Specify	v)
			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date o (Monti	f Injury h, Day Year)	28b. Time of Injury	2	8c. Injury Work	at ?	2	8d. Describe ho	w injury oc	curred	
DIVISION	To the Hospital or Attending within 24 hours atter death. To the Funeral Director: Attencompletely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	280. Place	of Injury - At h	ome, farm, str	M eet, factory		fes 2□N		28f. Location (Str City or Town	reet and Ni , State)	umber or Rura	I Route Number,
	To the Hospital or within 24 hours atter to the Funeral Dir completely filled in	Medical (29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exam	rsician: To the iner: On the ba and mann	isis of examina	owledge, death ation and/or inv	occurred a	at the tim in my op	e, date and pinion, deat	place, a	and due to the ca	use(s) and ite and pla	d manner as st ce, and due to	ated. the cause(s)
	To tl withi To tl comp	Σ	29b. Signature and title of certifier	(also)			29c	. License	number		29	d. Date si	gned (Month,	Day, Year)
			1684	105			D	0039	811		M	ARCH	12, 20	06
			30. Name and address of person who o							77 432	01500			
				OO MEMO			UMBER	LANI	, MARY	LANI	21502			
	Sta		31. Date filed (Month, Day, Year)		gistrar's Signa	ature	- 7							

			1- State of Ma		artment of Health and I	Mental Hygien	2006 00117
	Physici		1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Da	3. Time of Death
	/Medic Examir		4a. Equility Name (It not institution, give street and number)	ital	4b. City, Town, or Location of Death		County of Death
	Funeral Director		5. Social Security Number 214-24-1154 Usual Residence of Decedent	e (In yrs. last birthday, 83 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year, 1/11/23	9. Birthplace (State or Foreign Country) MD
	Maryland -f show	lor	10a. State 10b. County N/A	10c. City, Town or L	Baltimore		10d. Inside City Limits ★□Yes 2 □ No
	3a or 28a	Funeral Director	10e. Street and Number 5220 York Road Apt 2E	<u> </u>	10f. Zip Code 21212	10g. Ci	itizen of What Country?
036	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, it a Madical Examiliant and event, it a Madical Examiliant and event.	þ	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes 2 Xeven Widowed 4 Divorced	No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2 ☒ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	c * :5	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	(Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired) Nursery School	rking	(ind of Business/Industry Education
Maryland 2	should be filed withlind Mental Hygiene. marked other than imatic event, It a M	To Be C	17. Father's Name (First, Middle, Last) Unk.			ne (First, Middle, Maider	n Surname)
	es 1 and 2 s of Health ar filem 27 is rother trau		19a. Informant's Name/Relationship (Type, Print) James N. Dent /Son		ng Address (Street and Number or Ru Sparrow Court, Wi		
altimore,		-	20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Bay View	Crematory March	13, 2006 Ba	
Balt	permit, Pag Department important: t any injury o		21. Signature of Funeral Service Licensee Victor		2. Name and Address of Facility narles L. Stevens 501 E. Fort Avenue		me, Inc. e, MD 21230
8760,	death certificate be executed Wedical Ex Wedical For a set the burial-fransit For a set the burial-francin For a set the	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a consequence of):	ler the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
.O. Box 6	at the death certific by the attending p tached for use as it	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year	
Д.	ires tha signed d be de	eted by Ph	Part II. Other significant conditions contributing to death but	ut not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Vital Records,		Complet				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
of	Attanding Physician: 7 r death. actor: After this certifica by the funeral director, p	ition; To Be	25. Was case referred to medical examiner? 1 Yes 2 Hospital: Hospital: 1 Hospital: 27. Manner of Death 1 Hospital: 28a. Date of Injur (Month, Day 2 Accident investigation	ry 28b. Time o	nt 3 DOA Other: 4 Nursing H	ath (Check only one) lome 5 Residence 28d. Describe how inju	
Division	in Diffe	Certification;	3 □ Suicido 6 □ Could not be	ury · At home, farm, st. c. (Specify)	reet, factory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, e)
	To the Hospital or Attan within 24 hours after deatl To the Funeral Diractor: completely filled in by the	edicai	29a. Certifier (Check only one) 1 ertifying Physician: To the best of any manner sta	examination and/or in	h occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the cause(s rred at the time, date and) and manner as stated. d place, and due to the cause(s)
)	To t To t	Σ	29b. Signature and trie of certifier		Print) 29c. License number 000538	5 D 29d. Da	tie signed (Month, Day, Year)
	7		30. Name and addrass of person who completed gause of de	huart	Print) B	on Secol	ws Hopital
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 7 2006 32 Registra	ar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 9:50 AM 19 KY George Edward DuBree 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Citizens Haurede Geace Hartord Nursing Home If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1**X** M 2□ F Yrs. Director 216-07-1863 Maryland 09/15/1907 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic evant, the Medical Evantrar must be notified at 1 Yes 2 □ No Director MD Harkord Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 505 Congress Avenue, USA Apt. 106 21078 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6th Farm Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Stephen Thomas DuBree Florence Boyd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) itam 27 i Katherine Stout- Sister 750 Ohio St., Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Department of H Important: If its any injury or of once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Mem. Grdns. 03/14/06 Bel Air. MD 21. Signature of Funeral Service Licenses Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, 4 21078 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Stag disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Physician/Medicai IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. þ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1 Yes 2/2 No funeral director 25. Was case referred to predica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 ☑ № 6 this 27. Mann J Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attanding 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral L 1 retitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier tha 29b. Signature 29d. Date signed (Month, Day, Year) 0062903 10/06 Name and address on who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

George

Dubree,

ar MAR 1 7 200

31. Date filed (Month, Day,

900.

319 South Union Ave., Havre de Grace, MD 21078

ORIGINAL

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 23a per doc 9854 4-6-06 vt
State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 11 2006 2121 March Violet Virginia Diffenderfer /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Havre de Grace
If Under 1 Year | If Under 24 Hrs.
Months Days | Hours | Min. Harford Harford Memorial Hospital 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) 06/24/1923 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F Yrs. 82 Director 220-14-1676 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir then "netural", or Itams 23a or 28a-f ehow the Medical Examiner must be notified at 1X Yes 2 □ No Director Havre de Grace MD Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21078 100 Revolution St. Apt. 401 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Heelth and Mental Hygiene. Important: If Itam 27 is marked other then eny injury or other traumatic event Elementary/Secondary (0-12) Coltege (1-4or 5+) Home Homemaker 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Laura Singleton William J. Wright 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 439 Frist Road, Colora, MD 21917 <u>Deborah Rosenkrans-Daughter</u> 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Port Deposit, MD 03/17/06 Asbury Cemetery 21. Signature of Funeral Service Licensee Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine.

B—Cell Maly enant Lymphoma Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) 1devilost **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examine physicien and the burial-transit Hospitef or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending pl IF FEMALE: 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) P.0. certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes > No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 25. Was case referred to medical examiner? the funeral director. 26. Place of Death (Check only one) Be Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of After t Medical Certification; 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 ☐ Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination of or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) in inner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier and

DHMH 17 Rev 1/2001

State

Registrar

200 1

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 1 7 2006

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year MOZELL DAYE March 2:02 A M 13 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Baltimore pirtal 5. Social Security Number . Sex Date of Birth (Month, Day, Year) Funeral If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Months Days 1 ☐ M 2X F Hours Min. Director 80 216-16-6894 05/07/1925 CAROLINA Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 17 le marked other then "naturel", or itema 23a or 28e-f ebov traumatic event, the Mudical Examinar must be politied at N/A MD BALTIMORE CITY **Funeral Director** 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5060 HAMPSHIRE AVENUE 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2X No Specify: BLACK XXVidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10TH DOMESTIC HOUSEKEEPER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental FRED MAYS JESSIE THROPE ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Depertment of Health at
Important; If Item 27 Ie. 5060 HAMPSHIRE AVE., BALTIMORE, MD 21207 BRYAN DAYE / 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State MD VETERANSherC MD VETERANS CEM GARRISON FOREST 03/20/06 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licenses Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE, 1. First the 1 ease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, or read failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm - ate Cause (Final diseast or condition resulting in death) Myocardial Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month 4 Pregnant at time of death 5 Other (specify) P.O. 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 Completed 1 ☐ Yes 2 ☐ No 3 Probably been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Division of Vital 1 ☐ Yes funeral director 25. Was case referred to medical 26. Place of Death Check only on Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3/2 No 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred Director: After 28c. Injury at Work? Hospital or Attending 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by efter 4 Homscide within 24 hours e To the Funeral D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Adam Carinci Baltimore, Baltimore, MD 31. Date filed (Month, Day, Year) MAR 1 Registrar's Signature State 2006 Registrar

DHMH 17 Rev 1/2001

20

		_	For State Registrar		State	of Mai	ryland /	-	irtment tificate				lental Hy	giene Reg: No.	106	0	8121
			Decedent's Name (First	t, Middle, La	ıst)								2. Date of De	ath Day	Ye	ar	3. Time of Death
	Physicia /Medic		Benjamin	Gla	asco	Day	vis						MARCH	16	, 2006	5	06:55A M
3	Examin		4a. Facility Name (If not in	nstitution, giv	e street and nu	ımber)			4b. City,	Town, or	Location	of Death		4c.	County of D	eath	
0			VA MARYLAND	HEALT	TH CARE	SYS	rem				TILO				ECIL		
SC	Funeral		5. Social Security Number		Sex 1XIM 2□F	7. Age	(In yrs. last		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month Da Dec 5	th sy, Year),	9.	Birthpla Counts	ce (State or Foreign Land
GLASCO	Director	}	212-48-5391		143 W Z		58	Yrs.					Dec. 5,	194	F / IVE	агул	aiu
	pue *	1	Usual Residence of Dece 10a, State 10b.	County			10c. City, T	own or Lo	cation							100	d. Inside City Limits
1II	daryii ed	5	Maryland	Harfo	rd		Churc	chvil	le								1 ☐ Yes 2 ☐ No
BENJAMIN	the N	ect	10e. Street and Number						10f. Zîp	Code				10g. Cit	izen of What	Countr	y?
Ë	with bor	<u></u>	205 Asbury	Poad					2102					USA	1		
Щ	heath	Funeral Director	11. Marital Status	1000	12. Was Dec	cedent E	ver in U.S.	13.			spanic Or	igin? (Sp	pecify Yes or No Rican, etc.)	o-	14. Race - A		
ES,	r Iter	F	1 Never Married	2 Married	Armed F	orces?	0	'		_			Hican, etc.)		Black, W		
DAVIS -0036	al', o	þ	3 ☐ Widowed 4 🛣 🛭	Divorced	If Yes, G Year or I	ove Dates: 1	968 – 70	0	1 □ Yes 2	ZIM No	Specify.	:			Specify: B	lack	2
DAV.	72 ho	ted		Decedent's E	ducation ade completed)	1	6a. Deced	dent's Usua kind of wor DO NOT us	l Occupa	ation during mos	st of worl	cin g	16b. K	ind of Busine	ss/Indu	stry
	thin e.	npie	Elementary/Secondary	1	College		-))			TTo see	Sand C	t	- Cozz!+
1AN 2121	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f ehow ent, I'te Macircal Ezaminer must be notified at	Completed			3			Supe	erviso	or	40 14-4	- d- N	- Wind Adiabate			oun	ty Gov't
PHYSICIAN	d ta b	Be	17. Father's Name (First,		t)		Darri	-				ers Nam Lira	e (First, Middle	, <i>maiden</i> ank)	Sumame)	Sm ⁻	ith
yla yla	Men Men arke	은	Robert	C.			Davi								. T O		
lar P	2 sho	9 6	19a. Informant's Name/F Kim Davis/I	-				196. Mailir 2102	rg Address Fores	Street a	a <i>na Numb</i> de Dr	ive.	ra <i>l Route Numb</i> , Aberde	er, chy c een ,	Maryl	and	21001
0, €	1 and 1 Health em 27 other tr		20a. Method of Disposition				-		sition (Nan				Date		ocation - City		
₹ o	Pages nent of H int: if Ite		1 🗆 Burial 2 💆 Cre	emation 3 (State	cem	etery, crei	natory or o	ther plac	· 1	02_1	8-06				
KNOWN TO PHYSIC Baltimore, Maryland	permit. Pages 1 and 2 should Department of Health and Men Important: if Item 27 is marke any injury or other traumatic. Once.		* 4 □ Donation 5 □ 21. Signature of #uneral				11777	20	erv.	d Addros	es of Eacil	ity			vson,		
na ⊠	Dermi Depa Impo any i		21. Signature of Aurieral	1 1 //	9	, 2		Mc	Coma.	, Fu	neral	Hon	ne, P.A i, Abin	• 4	7.6		3 03 000
NAME			23a Part 1 Foter the dis	sease or cor	nolication has	used	the death. I	Do not ent	er the mod	DKES! e of dvin	OULTY a. such as	ROAC cardiac	or respiratory	rrest.	. Mary		Approximate
_			23a. Part1. Enter the dis shock, or heart fail Immediate Cause (Final							, .,	3,		,			(nterval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)				CANCE									U	INKNOWN
	Examiner				Due to	o (or as a	consequen	ice of):									
		<u>-</u>	Sequentially list condition	ns,	b. Due to	o (or as a	consequen	ice of):								_	
B	ted nsit	Examiner	Sequentially list condition if any, leading to immed cause. Enter Underlying Cause (Disease or injury)	~												4	
	al-tra	Exal	that initiated events resulting in death) Last		c	o (or as a	consequen	ice of):									
760,	ate be executed thysician and the burial-transit			•	d												
	Attending Physiclen: The law requires that the death certificate be executed relath. sector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical												-		15	
ŏ	death certifica attending ph I for use as th	2	IF FEMALE: 23b. Was decedent preg	gnant	23c. If yes, o	utcome o	of pregnancy 2 Fetal de	y noth 3	Ectopic pr	oonancu					23d. Date of		
m.	death e atte	icia	in the past 12 mont 1 ☐ Yes 2 ☐ No	ths?		gnant at t	time of deat		Other (sp						Month		Day Year
O.	t the by the tache	hys	9 🗌 Unknown		9LJ Unk	nown							-				
Division of Vital Records, P.O. Box 6	n requires that the death cer been signed by the attendir should be detached for use	by P	Part II. Other significant	conditions	contributing to	death bu	t not resultir	ng in the u	nderlying c	ause giv	en in Part	ł.					cause of death?
<u>p</u>	aquire en siç ould b												1 🗆	Yes 2	∐No 3□	Proba	bly 4 🛣 Inknown
o O	aw re	Completed											24a. Wa	ansv	prior	e autop	sy findings available pletion of cause of
R	The I	E											perf 1 ☐ Yes	ormed?	deat	h? Yes 2	
tal	an: rtifica tor, p	0	25. Was case referred to	medical							26. Plac	e of Dea	th (Check only			-	
<u> </u>	ysicl is cer direc	To B	examiner? 1 ☐ Yes 2 🛣 No		Hospital: 1] Inpatier	nt 2 EP	VOutpatie	nt 3 🗆 DC	Oth Oth	er: 🗶 N	lursing H	ome 5 🗆 Res	idence	6 Other (Specify)	
0	ig Ph ter th	Ë	27. Manner of Death	☐ Pending	28a. Dat (Mo	e of Injur	y Year) 28	Bb. Time o	f 2	8c. Injun Wor	y at k?		28d. Describe	how inju	ry occurred		
<u>.</u>	andir ath. or: Af	atic	2 Accident	investigati					М	1 🗆	Yes 2]No					
<u>≥</u>	r Att	Certification;	3 ☐ Suicide 6	Could not determine	d 28e. Plae buil	ce of Inju Iding, etc	ry - At home . (Specify)	e, farm, st	reet, factor	, office			28f. Location City or To	(Street all own, State	nd Number o e)	r Rural	Route Number,
0	rs after ral Dir																
	To the Hospital or Attending Physiclan: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2	Certifying F Medical Ex	Physician: To the aminer: On the	basis of	examination	edge, deat n and/or in	h occurred vestigation	at the tin , in my o	ne, date a pinion, de	ind place ath occu	, and due to the rred at the time	e cause(s e, date an) and manne d place, and	due to	ited. the cause(s)
	the hin 2 the I	Med	one)	of contifier	and ma	nner sta	tea.		296	Licens	e number			29d. Da	ite signed (A	fonth, D	Pav. Year)
	Viit To		29b. Signature and title	or certifier	7												,. ,
	1		· /ch	0	~/-	177			-	5723	9		117	9-/	6-06		
	lot		30. Name and address of							CAL	E 037	C(DE)M	DEBBA	DOT	ит мг	21	902
	Ψ'		SURESH SHAN 31. Date filed (Month, D		349	Registra	r's Signatur	H CINIA	EALTH	CAR	E DX	STEM	, PERRY	PUI.	LVI / LIT	, 41	J V L
	Sta Regist	ate rar		1 7 25	nc les	10.10	N.	S. Trans									
			CIRK	1 7 /	HIT ELEC	The state of the s		407									

Amend item#19a,perrH,0853, 3/20/06 TI State of Maryland / Department of Health and Mental Hygiene () () 6 08122 1 - For State Registrer Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) March 6:35 р. м 15, 2006 Physician Eugene Doyle Raymond /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Stella Maris Baltimore Co. Timonium | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 8, 1925 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 ☐ F Mary land 80 Yrs. 218-12-5000 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. importent: if item 27 is marked other than "naturat", or itams 23a or 28a-f show any injury or other traumatic event, the Madical Examinist invist be incitified at once. 1 X Yes 2 ☐ No Maryland N/A Baltimore Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4546 Hazelwood Avenue 21206 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: Korean Specify: White Specify: 3 Nidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore City Elementary/Secondary (0-12) 12 yrs. College (1-4or 5+) Furniture Repairman Dept. of Education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lilly Olive John Walter Inks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4546 Hazelwood Avenue Baltimore, Maryland 21206 Mr. Harry Dolye 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest VA Cem. 3/22/2006 Owings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service vicensee Michael E. Canapp 22. Name and Address of Facility 5305 Harford Road Baltimore, MD 21214 Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** PARKINSON'S DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown I signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 autopsy performed? Yes 2 No this certificete has 1 ☐ Yes Division of Vital funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 1 Yes 2 No Certification; To 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? or Attending 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No ours after death neral Director: A 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and Atle of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 1 Registrar

RAYMOND DOYLE

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

2006

			for State Registrar	State of Maryland / Depa	artment of Health and N	Mental Hygien	2006	08124
	Physici /Medic		1. Decedent's Name (First, Middle, Last) ShirkLEY JEF	N FARMER		2. Date of Death	ay Year S ZOOL	3. Time of Death
	Examin		4a. Facility Name (If not institution, give s 8013 TICK NECK	treet and number)	4) City, Town, or Location of Death	أم	c. County of Death	untel
	Funeral Director		33 1-23-1703	M 200F 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthy	place (State or Foreign http://
	Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County ANNE AD	10c. City, Town or Lo	ocation A IA			10d. Inside City Limits 1 ☐ Yes 2 🗖 No
	with the 3a or 28e-	Funeral Director	10e. Street and Number 2013 Tick NFCk	Ro.	10f. Zip Code 21122	10g. C	Citizen of What Cou	ntry?
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28e-f show or other traumatic event, Ite Madical Examinat must be retilled at		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Provorced	1 ☐ Yes 2 7No	Was Decedent of Hispanic Origin? (Stiff Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- D Rican, etc.)	14. Race - Americ Black, White,	
21215-0036	i within 72 ho iene. • than "natur it e Majiral	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) (Give	dent's Usual Occupation I kind of work done during most of work DO NOT use retired) DEFANER	king A4	Kind of Business/In	dustry
Maryland 2	should be filed nd Mental Hygid marked othar Imatic event, II	To Be Co	17. Father's Name (First, Middle, Last) WILBUR MARION	Smith	18. Mother's Nam	e (First, Middle, Maide MAY Li	an Sumame)	
	and 2 sho lealth and h m 27 la ma her trauma		19a. Informant's Name/Relationship (Ty)	DAUGHTER BOIS	ng Address (Street and Number or Tu	ral Route Number, City	or Town, State, Zip	Code)
Baltimore,	Pages 1 ment of He ant: If itan ury or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	MANUTE AN 11	osition (Name of matory or other place)	8-06 HA	Location - City or To	own, State
Balt	permil. Pages Department of Important: If ii any injury or o		21. Signatur of Furn 1 Servi License		 Name and Andress of Lacility Daugherty Family Funeral H 2601 Mountain Road 	- Pasadena, MD.	1 Center, P.A. 21122	
	Enysician		Immediate Cause (Final disease or condition	cations mat caused the death. Do not en e cause on each line. Metastatic Cent	ter the mode of dying, such as cardiac			Approximate Interval Between Ouser and Death
	/Medical Examiner	L	resulting in death) Sequentially list conditions,		*	/		
V	ecuted and I-fransit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):				
68760,	icate be executed physician and s the burial-transit						-	11111
O. Box (that the death certific ed by the attending p detached for use as	Completed by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
ds, P.	w requires that to be some signed by should be detailed	d by Ph	Part II. Other significant conditions con	tributing to death but not resulting in the u	inderlying cause given in Part I.		o use contribute to t	he cause of death?
of Vital Record	(d)	Complete	Deleter	Redutus		24a. Was an autopsy performed?	prior to co	opsy findings available impletion of cause of 2 No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:	Other	th (Check only one)		
	ling Phys	atlon: To	1 Yes 2 No 1 27. Manner 1 th 1 tural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ ER/Outpatien 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	nt 3 DOA 4 Nursing H	ome 5 (Residence 28d. Describe how in		ýy)
Division	al or Attancs after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Run ite)	al Route Number,
	To the Hospital or A within 24 hours after To the Funerel Direct completely filled in by	edical (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examil	sician: To the best of my knowledge, deat ner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, ivestigation, in my opinion, death occur	, and due to the causer rred at the time, date a	(s) and manner as s ind place, and due t	stated. the cause(s)
١	To the vithin To the comple	Me	29b. Signature and title of certifier		29c. License number		Date signed (Month,	Day, Year)
,	2	ĺ	30. Name and address of person who co	Mileted cause of death (Item 23a) Type, 17-0 802 Ki77		CADBAA, A	10 2112	7
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 7 200	32. Registrar's Signature	Addition to the second			

			artment of Health and Mental Hygiene rtificate of Death Reg. No. 006 08125
Physi		HELEN A. FACHEE	2. Date of Death Month Day Year March 16, 2006 3. Time of Death 1:20 A M
/Med Exam	dical niner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
	Sec.	Futurecare Chesapeake	Arnold Anne Arundel If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9 Birthplace / State or Foreign
Funera Directo	_	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 179-12-8565 1 M 2 XX 87 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. June 24, 1918 9. Birthplace (State or Foreign Country) PA
yland how		10a. State 10b. County 10c. City, Town or L	
Ba-f e	cto	MD Anne Arundel Arnold	1 □ Yes 2 □ No
with the Sor 2	Dire	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country? USA
leath ns 23	e La	305 College Pkwy 11. Marital Status 12. Was Decedent Ever in U.S. 13.	
ITC; MIGITY INTELLATIONSO Is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "neturel", or Items 23a or 28a-f ehow other traumatic event, the Medical Examinations to refilled at	by Funeral Director	Armed Forces? 1 ☐ Never Married XX Married 1 ☐ Solution 1 ☐ Never Married XX Married 1 ☐ Never Marri	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1□ Yes ★★No Specify: 14. Race - American Indian, Black, White, etc.
hours at turel; or			White Ident's Usual Occupation 16b. Kind of Business/Industry
hin 72	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	skind of work done during most of working DO NOT use retired)
ed will ygiene rethe	Com	12	Homemaker Own Home
Vidiro buid be file Mental Hy arked oth atic event	8	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame) Susanna McCafferty
should nd Me mark mark	ŗ		ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
y FVIC and 2 valth a 27 is er trau			Scott Glen, Glen Burnie, MD 21061
or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3√√2Removal from State 20b. Place of Disposition cemetery, cree	matory or other place)
permit. Pages 1 Department of H Important: If ite ony injury or ot		4 Donation 5 Other (Specify)	erabulem 3-22-06 SPRINGFIELD PA
Dependent of the property of t	8308		2. Name and Address of Facility Fink Funeral Home, P.A. 426 Crain Hwy SW, Glen Burnie, MD 21061
Physicial /Medica Examine	al er	23a. Part 1 Enter the disease or combidations that caused the death. Do not en shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	ter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onstitution Death
ding Physician: The law requires that the death certificate be executed h. After this certificate hes been signed by the ettending physician and funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	resulting in death) Last C	
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	□Ectopic pregnancy 23d. Date of delivery Month Day Year
law requires that as been signed 2 should be dei	à	Part II. Other significant continuous contributing to death but not resulting in the	
The law rate hes be page 2 sh	Completed		24a. Was an autopsy autopsy findings available autopsy performed death? 1 Yes 2 I No 1 Yes 2 No
VICAL Ician: Dertifical	B	25. Was case referred to medical examiner?	26. Place of Death (Check only one)
Phys rthis	2	1 Inpatient 2 EH/Outpatie	
Attending at death. Attending by the fune	atlor	1 【Natural 5 □ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	Certification:	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)
he Hospil in 24 hour he Funera pletely fills	Medical		th occurred at the time, date and place, and due to the cause(s) and manner as stated. evestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To T	2		29c. License number 29d. Date signed (Month, Day, Year) 3-16-2006
)	State	30. Name and address of person who completed cause of death (Item 23a) (Type CP) 1. Date filed (Month, Day, Year) 31. Date filed (Month, Day, Year) 34. Registrar's Signature	2 050725 3-16-2006 Externs thuy Millersville 2/108
Regis	strar	MAR 1 7 2006	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 13 Year **Physician** 8:48 PM Edith LaReine Foxwell MARCH 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMOKE HOSPITAL ST. AGNES 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕽 F 216-09-8035 89 Vrs Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r then "natural", or iteme 23s or 28s-f show the Medical Examinar must be notified at 1 Tyes 2000 MD Baltimore Halethorpe Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5711 First Avenue 21227 U.S.A. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Yes 2 ◯ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white þ 3€CXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fill h and Mental H 7 is marked ott Emil William Fosburg Amanda Ann Puepke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 le
any injury or other trau Joan L. Ainge/Niece 907 Cindy Lane Westminster MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Qonation 5 □ Other (Specify) Mar. 16, 2006 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Ambrose Funeral Home, Inc.
1328 Sulphur Spring Rd. Arbutus MD 21227 23a. Part1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY FAILURE 2 DATS HYPOXIC **Physician** /Medical Due to (or as a consequence of): Examiner EXACERBATION 1 WEEK PULLIDUAIRT DISEASE CHRONIC OBSTRUCTWE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and the burial-transit WEEK PNEUMONIA Due to (or as a consequence of): P.O. Box 68760, Physician/Medicai as IF FEMALE: 950 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records. page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an autopsy performed? certificate has Vital 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3□ DOA Division of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier maria Carmela n. Kosales, MD P18614 MARCH 13, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 212201 MAIRIA CAKCUTELA N. 1205ALES MD CATON AUE, BAUTIMORE, MD 31. Date filed (Month, Day, Year) 32. egistrar's Signature State MAR 1 2006 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

			State of Marylar	•	te of Death		ene 9. No 0 0 6	08127
	Dhysician	1. Decedent's Name (First, Middle, Last	()			2. Dete of Deeth Month	Day Year	3. Time of Death
-	Physician /Medical	Dorothy A. Fincha				March 3	, 2006	5:15 AM
	Examiner	4a Fecility Neme (If not institution, give Northampton Mano)			Freder		4c. County of Death	
-		5. Social Security Number 6. Se			r 1 Year If Under 24 H	rs. 8 Date of Birth		place (State or Foreign intry)
	uneral irector	577-32-5127	^{□ M 2} ∏F 86	Yrs. Months	Days Hours M	in. (Month, Day, Aug 4,	1919 Mary	1and
g	2	Usual Residence of Decedent 10a. Stete 10b. County	10c C	ity, Town or Location				10d. inside City Limits
Aaryle	r short	MD Montgome		Kensington				1 ☐ Yes 2√∑ No
the	or 28a-f s be notified Director	10e. Street end Number	Ly	10f. Zi	Code	10	Og. Citizen of What Co	untry?
h wit	23a or	10920 Connectic	ut Avenue #41	.5	20895		USA	
1215-0020 within 72 hours after deeth with the Marylend	if them 27 is marked other than 'natural', or items 23a or 28a-f show or other traumatic event, the Medical Exprinter must be notified at or other traumatic event, the Medical Exprinter must be notified at To Be Completed by Funeral Director	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		dent of Hispanic Origin? cify Cuben, Mexican, Pu 2双 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Amer Black, White Specify: W	
15-0	the Medical of Completed	15. Decedent's Edi (Specify only highest gred	de completed)	16e. Decedent's Usu (Give kind of we life. DO NOT u	ork done during most of w	vorking	16b. Kind of Business/I	ndustry
212 d with	the mo	Elementary/Secondary (0-12)	College (1-4or 5+)	homem	aker		own home	
the filed	d other went.	17. Father's Name (First, Middle, Lest)	_			lame (First, Middle, N		
aryla should i	To marke	William Edwin N		40h Mailine Address	Samar s (Street and Number or	ntha Helen		in Code)
Man day	7 la n traur	19a. Informant's Name/Relationship (T) Shirley Norris/da			state Drive			
Baltimore, Maryland 21215-0020 pemit. Pages 1 and 2 should be filed within 72 hours aft papartment of Health and Memia Horiene	Important: if Item 27 any Injury or other ti	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ፟፟ Donation 5 ☐ Other (Specify,	Removal from State	Place of Disposition (Na cemetery, crematory or	me of other place)	Date 2	20c. Location - City or 1	own, State
Balti Permit.	Important any Injury pnce.	21. Signature of Funeral Service Licens	Wade, Division		Anatomy Boa ore, MD 21	rd 655 W. 201	Baltimore	Street
		23a. Part1. Enter the disease or comp shack, or heart failure. List only of	lications that caused the dea	th. Do not enter the mo	de of dying, such as card	iac or respiratory arre	est,	Approximate Interval Between Onset and Death
/M	rsician ledical aminer	Immediate Cause (Final disease or condition resulting in deeth)	Due to (OBSTRACT	INZ PLIC	-MON ARY	DISBASE	Yeurs
	ě		Due to ((or as a consequence of)	mod we			la Game
ecuted	g physician and es the bunal-trensit			or as a consequence of)			1	JAMA
68760, ficate be execut	burial burial	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c				1	
68760, ficate be ex	physicia ss the bur edical	resulting in deeth) Last	Due to (or as a consequence of)				
Box eath certi	esn .		d				<u> </u>	
deat	ed for	Part II. Other significant conditions co	ntributing to death but not re	sulting in the underlying	cause given in Part I.	23b. Did to	bacco use contribute	to the cause of death?
P.O.	gned by the attending be detached for use to be detached for use to by Physician/M	ATRIAL FIL	BRILLATIO	W		1 □ Ye	8 2□ No 3⊒Pr	obabiy 4 Unknown
ds,	d be d					24a. Was ar	n autopsy 24b. V	Vere autopsy findings
COL	sata has been si pege 2 should Completed					perform	C	vailable prior to completion of cause f death?
Be je	ege 2					f CJ Va	is 212No 1	☐Yes 2☐No
	actor, p	25. Was case referred to medical examiner?			26. Place of D	Death (Check only one	9)	
Z og	Il direc	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐				nce 6 Other (Spec	sify)
On C	After t funera	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28e. Date of Injury (Month, Dey Yeer)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho	w injury occurred	
Division of Vital Records, to Attending Physician: The law requires talliar death.	ol Director: After the ad in by the funeration:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury - At h building, etc. (Speci	nome, farm, street, factor		28f. Location (Sti City or Town	reet end Number or Ru n, State)	ral Route Number,
ne Hospita	Plataly fill	(Check only 2 Medical Exami	sician: To the best of my known and the basis of examination and manner stated.			curred at the time, da	ate and place, end due	to the cause(s)
To th	To th comp	29b. Signature and title of certifier			c. License number		9d. Date signed (Monti	
		· well		M.D.	02649		3-9-0	40
		30 Name and eddress of person who c	ompleted ceuse of deeth (Ite	m 23e) (Type, Print)	1 A.	ris m	D 21	171
	State	31. Date filed (Month, Day, Year)	32. Registrer's Sign	ature	11.	1		. ,
	Dogistrar	MAR 1 7 200	6 1000	2 Locales				

			1 - For State Registrar	State of M	Maryland		artment o			Mental I	lygien Reg. N	THE	08128
	Physici	an	1. Decedent's Name (First, Middle							2. Date o Month	D	ay Year	3. Time of Death
	/Medic		Bertha		Harris			een			10	2006	5:p M
}	Examir	ier	4a. Facility Name (If not institution 1108 Harford	Avenue				alti	more			ic. County of De	
	Funeral Director		5. Social Security Number 213-36-7124 Usual Residence of Decedent	6. Sex 7 1 ☐ M X☐ F	Age (In yrs. la	a <i>st birthday)</i> Yrs.	If Under 1 You Months Da		Jnder 24 H ours M	in. (Month	Birth <i>Day,</i> Yea 7–37	r) 9. B	irthplace (State or Foreign Country) Md.
	/łand		10a. State 10b. County		10c. City	r, Town or Lo	ocation						10d. Inside City Limits
	Many Many	ţō	Md. N	IA		Balti	more						X□Yes 2□No
	or 28	Director	10e, Street and Number				10f. Zip Coo				10g. C	Citizen of What C	Country?
	ath w	ral	1108 Harford				212			.2		USA	
396	be filed within 72 hours after death with the Maryland stal Hygiene. Id other than "natural", or items 23e or 28e-f show event, ite Medical Evarities must be notified at	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	s? No		Was Decedent If Yes, specify (1 ☐ Yes 2		nic Origin? lexican, Pu pecify:	(Specify Yes o erto Rican, etc.	No-	14. Race - Am Black, Wh Specify:	
21215-0036	c • a	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)		or 5+)	(Give	dent's Usual Oo kind of work do DO NOT use re	one durini	g most of v	vorking	16b.	Kind of Busines	s/Industry
21	filed with Hygiene. Ither than	Com	12th grade			Dis	abled					NA	
Ind	should be filed within and Mental Hygiene. marked other than imatic event, tra M	Be	17. Father's Name (First, Middle,	Last)				18.	Mother's N	lame (First, Mic	ldle, Maide	en <i>Sumame)</i>	
Z	2 should be f and Mental H Is marked of aumatic ever	To	Andrew	hin (Time Drint)	Ha	arris	as Address /Ct		*	rlotter			Moore To Code
Maryland	2 8 8 5		19a. Informant's Name/Relations Lydia Anderson		bae		.08 Harf				_	or Town, State,	202
	of Health Item 27		20a. Method of Disposition		20b. PI	lace of Dispo	sition (Name o	of	Ave.	Date		Location - City of	
Ö	Page ento nt: If ry or		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		10		matory or other rmel Ce		3-	-15-06	Di	undalk,	Md.
Baltimore,	그 돈은 것	ļ	21. Signature of Funeral Service				2. Name and Ad		Facility	Bal	_	e, Md.	21202
ñ	Department of the post of the		Mlad	wo wa	سم		March	F.H.	East	110	l E.	North A	ve.
	Physician /Medical Examiner und invisicien and phural-transit transit	al Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. Cri Due to (or . Chr Due to (or .	as a conseque	uence of):	ortic	2 5	den	un s			Interval Between Onset and Death 2 () \ 5
P.O. Box 68760	t the death certific by the ettending p ached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 25 No 9 □ Unknown	d. 23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal at time of de	death 3	⊒Ectopic pregna ∃ Other (specify					23d. Date of d Month	elivery Day Year
	w requires the been signed I should be det	by	Part II. Other significant condition	ons contributing to death	n but not resu	ulting in the u	inderlying cause	given in	Part I.		id tobacco	_	to the cause of death? Probably 4 Unknown
Vital Records,		Completed								- a	Vas an utopsy erformed?	prior to death?	
/ita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?			1100			Ptace of D	eath Check of	nly one)	We'	
ð	S S D	5	1 Yes 20No 27. Manner of Death	Hospital: 1 ☐ Inpa 28a. Date of I		ER/Outpatie			Nursing	_		6 □Other (Sp	ecify)
Division	ding h. After fune	Certification:	Natural 5 Pendin Investig	g (Month, I	Day Year)	Injury me, farm, st		Injury at Work? 1 Yes	2 🗆 No	28f. Location		and Number or I	Rural Route Number,
ō	To the Hospitel or Attenwithin 24 hours efter death To the Funerel Director: completely filled in by the	edical Cert	29a. Certifier Check only Medical	g Physician: To the be Examiner: On the basis	st of my know	wledge, deat	h occurred at the	ne time, d	ate and pla	ice, and due to	the cause	(s) and manner a	as stated.
	the H	Med	one)	and manner		-		cense nur			-		
	P V CO		29b. Signatura and titte of certifie	1	2.20	- Mi	1 1	47	5/2	2	23U. L	ate signed (Mor	, Day, 1841)
,	η		30. Name and address of person	who completed causes	of death /Itom	23a) /Tunn	Print)	1 1	-W		Ī	2/1[U
	2		Patricia CL	and completed cause of	Mean (Item	23a) (1ype,	9 FAC	ts.	. A.	E A	Hi	nonch	10 21224
	Sta		31. Date filed (Month, Day, Year)	32, Regi	strar's Signat	ture	AP T			Se local			
	Regist	rar	MAR 1 7	2006 1	100 1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 15, 2006 Year Viola Gertrude Griffin /Medical 4:40 РМ 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center For Hospice Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Oct. 12,1914

8. Bate of Birth (Country)

9. Birthplace (Country)

Maryland 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months 1 ☐ M 367F 213-18-6823 Director 91 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f ehov traumatic event, the Madical Examiner must be notified at 10d. Inside City Limits Director Maryland Baltimore Essex 1 ☐ Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 429 South Taylor Avenue 21221 U.S.A. 'naturel', or iteme 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes ★★ No If Yes, Give Year or Dates: à 1 ☐ Yes 2 XXIvo Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed withi Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home and Mental Hygie Maryland 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Jerry Krecher Jeannette McCafferty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Sharon Hitt (Daughter) 1316 Cherry Garden Road, Baltimore, Maryland 21221 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ← Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens Of Faith March18,2006 Baltimore, Maryland 21. Signature of Funeral Section Linesee 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A.
1407 Old Lastern Avenue, Essex, Maryland 21221
Approximate 23a. Part1. Fam. thr. isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Dementea Alzhamer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months?

1 Yes 2 No
9 Unknown 4□Pregnant at time of death Month 5 Other (specify) 9 Unknown ል Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ξ Completed 1 🗌 Yes 2 1 No 3 Probably 4 □Unknown hes l 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificete 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မ 2 ER/Outpatient 3 DOA rector: After this by the funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 26b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Dire 4 Homicide ŏ within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

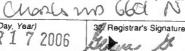
State Registrar

31. Date filed (Month, Day, Year)
MAR 1 7 2006

30. Name and address of person who completed cause of death (Item 23a) Type, Print)

29b. Signature and title of certifier

Agron





29c. License number

ST

29d. Date signed (Month, Day, Year)

strune mo

2006

March 15

				For State Registrar	State of Maryland /		Health and Me	ental Hygi	•	00100
				Decedent's Name (First, Middle, Las	t)			(- 4		3. Time of Death
		Physici /Medi	cal	Katharine Gregory 4a. Facility Name (If not institution, give	Gelder	Ab City Town	or Location of Death	Month 3	Day Year O 6	700 AM
		Examir	ner	ad a		HAURE			Harton	, /
		Funeral		5. Social Security Number 6. Se		birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		ice (State or Foreign
		Director		046-28-9593 Usual Residence of Decedent	□M 2X0F 73	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, 10/18/1	932 Penns	ylvania
		yland how		10a. State 10b. County	10c. City, To	own or Location			10	d. Inside City Limits
,		within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-1 show the Modical Exercitor Livet be modified at	Funeral Director	MD Harford 10e. Street and Number	Havre	e de Grace 101. Zip Code		10	g. Citizen of What Count	1 □ Yes 2 No y?
		23e o	ai Di	4035 Webster Road	<u> </u>	21078			USA	
W		ems er	iner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of If Yes, specify Cul	Hispanic Origin? (Spec ban, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - America Black, White, e	
3	36	rs afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 【② Divorced	1	1 ☐ Yes 2 💯 No			Specify: Whi	
8411	5-0036	72 hours natural', Jical Ext	ted	15. Decedent's Ed (Specify only highest grad	ucation 16	Sa. Decedent's Usual Occu	pation during most of working	1	6b. Kind of Business/Indu	ustry
w	21	swithin 72 ho piene. r than "natur the Modicel	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retin	ed)			
y	121	led lygi har nt,		17. Father's Name (First, Middle, Last)	6 years	Teacher	18. Mother's Name		lementary S	chook
18	anc	b d la la la la la la la la la la la la la	o Be	Basil M. Gregory			Evelyn Ma		alden Sumame)	
X	Maryland		J.	19a. Informant's Name/Relationship (7	ype, Print) 1	9b. Mailing Address (Stree			City or Town, State, Zip (Code)
w)				Greg Gelder- Son		4131 Rock Ru	n Rd., Hav	re de Gr	ace, MD 210	78
W	Baltimore,	of Healt of Healt if itam 2		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □		of Disposition (Name of tery, crematory or other plants	ace)	ite 20	Oc. Location - City or Tow	n, State
10	ij	tment of I tant: If it		*4 ☐ Donation 5 ☐ Other (Specify	R.A. 1	Ferris and C		06 We	st Chester,	PA
W	Bal	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licen:	500	22. Name and Addr Mitchell-S	ress of Facility mith Funero	il Home,	P.A. Grace, MD 2	1076
19			-	23a. Part1. Enter the disease, or comp	plications that caused the death. Done cause on each line.	o not enter the mode of dy	NUNGTON, HO ring, such as cardiac or	respiratory arres	Grace, MV 2	Approximate
		Pnysician		Immediate Cause (Final	0.		1			nterval Between Onset and Death
		/Medical		disease or condition resulting in death)	a. Oue to (or as a consequence		ientia			
		Examiner		Sequentially list conditions,	. Seizure					
	V	led sit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	ce of):				
		sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence	ce of):				
	760,	siciar siciar e buri	cai		d					
	68	rtificat ng phy i as th	Medi	IE ECMAI E.	- M					
	Box 68	death certificate rattending physi of for use as the t	lan/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea		су		23d. Date of deliver	y Day Year
	P.O. E	it the dea by the a tached for	Physician/Medi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐ Unknown	5 Other (specify)				,
	٥.	res that the igned by be detact	y Ph	Part II. Other significant conditions co	ontributing to death but not resulting	g in the underlying cause g	ven in Part I.	23e. Did toba	acco use contribute to the	cause of death?
	rds	w requires been sign should be	ed by					1 🗌 Yes	2 No 3 Proba	bly 4 Honknown
	ဝဘ္က	aw re	piet					24a. Was an autopsy	24b. Were autops	sy findings available pletion of cause of
	I Re	The la ate ha	Completed					performe	ed? death?	
	/ita	ticien: The certificate harector, page	Be	25. Was case referred to medical examiner?	Ho enitely		26. Place of Death			
	of \	Physi this c	. To	1 Yes 2 No	to provide the second second	Outpatient 3 DOA		e 5 Residen	ce 6 Other (Specify)	
	O	ding I th: : After s funer	tlon	1 atural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury Wi	ork? □Yes 2□No	5d. 2000/100 1101	injury cooding	
	Division of Vital Records,	Attar er dea ector by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		farm, street, factory, office	25	3f. Location (Stre	et and Number or Rural	Route Number,
	Ö	itel or rs afte ral Dir led in								
		To the Hospitel or Attanding Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	vsician: To the best of my knowled iner: On the basis of examination and manner stated.	ige, death occurred at the and/or investigation, in my	time, date and place, ar opinion, death occurred	nd due to the cau d at the time, dat	ise(s) and manner as sta e and place, and due to l	ted. he cause(s)
		To the To the Comp	Ž	29b. Signature and title of certilier			nse number	296	d. Date signed (Month, D	ay, Year)
							62903	C	3/10/06	
		12		30. Name and address of person who d	completed cause of death (Item 23a		Havre 1)e Grac	0 71178	
		Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature		Favic 1	Je O IAC	510,10	
		Regist		MAR 1 7 2	2006 Segues 15	position				

		•	State of Maryland / Department of Health and N 1 - State Registrer Certificate of Death		iene	08131
	. Division		Decedent's Name (First, Middle, Last)	2. Date of Deat		3. Time of Death
	Physicia /Medic	al	Gloria C. Greene 4a. Facility Name (If not institution, give street and number) / / / Ab-City, Town, or Location of Death	March	15, 2006 4c. County of Deatl	420 p M
	Examin	er	Mary and General Hospital Bultimore C	fy	N/A	
	Funeral Director		5. Social Security Number 219-18-6028 6. Sex 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Min.	8. Date of Birth Month, Day. 1/22/19	Year) 9. Birtl 26 Mar	nplace (State or Foreign unitry) 'y land
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	e Mary Sa-f eh	Director	Maryland Harford Co. Bel Air			1 ☐ Yes 2 X No
	death with the Maryland rms 23a or 28a-f ehow		705 S. Fountain Green Road 21015	1	Og. Citizen of What Co United Sta	
		by Funerai	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes, Sive Year or Dates: 13. Was Decedent of Hispanic Origin? (Single Year or Dates) 14. Was Decedent Ever in U.S. Amed Forces? 15. Was Decedent of Hispanic Origin? (Single Year or Dates) 15. Was Decedent Ever in U.S. Amed Forces? 16. Was Decedent Ever in U.S. Amed Forces? 17. Was Decedent of Hispanic Origin? (Single Year or Dates)	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify: W	
RPE 1215-0	E . C .	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 vrs 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Wire Assembler	king	16b. Kind of Business/ Westinghous Electric Co	se
() L W	2 should be filed with and Mental Hygiene is marked other tha eumatic event, Ins.	Be Co	/ y13.	ne (First, Middle, I		J.
$\mathcal{N}\mathcal{U}$ (Maryland	should be ind Menta i marked umatic ev	ToB	Vincent Chiodi Mary	Cremi		
C. Mar	and 2 sh Baith and n 27 is m		19a. Informant's Name/Relationship (Type, Print) Mr. Robert E. Raber, JrSon 416 Campus Hills Driv		ir, Marylaı	
Baltimore,	8 = 5		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	2/2006	20c. Location - City or Owings Mi	
Balti	permit. Pa Departmer Important: any injury		21. Signature of Funeral Gervice Licensee Michael E. Canapp 22. Name and Address of Facility Leonard J. Ruck,		5305 Harfor Baltimore,	
	2		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each, line.			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. ///L + a bo / c	$\overline{}$,	0.100, 2.10
	Examiner		Sequentially list conditions, Lower Gastroin Astroal	Sheel	1	
18	ted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
8760,	cate be executed obysician and the burial-transit	al Exar	that initiated events resulting in death) Last Due to (or as a consequence of):	-		
9	sate phys the	dedical	d			
P.O. Box	The law requires that the death certific to has been signed by the attending page 2 should be detached for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of deli Month	very Day Year
	quires that the de n signed by the a uld be detached t	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute to	. 0
Division of Vital Records,	The law requir ate has been si bage 2 should I	Completed		24a. Was a autops perfori	med2 death?	topsy findings available completion of cause of
Vital	ician: certifica ector, p	Be	examiner?	ath (Check only on		
o	g Phys er this eral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		ence 6 Other (Spec ow injury occurred	cify)
isior	To the Hospital or Attending Physician: The law within 24 hours effer death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e, Place of Injury - At home, farm, street, factory, office	28f. Location (S	treet and Number or Ru	ıral Route Number,
Div	rs efter ai Dire	Certi	4 Homicide building, etc. (Specify)	City or Town		
	Hosp 24 hou Fune etely fil	Medicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and manner stated.	, and due to the c irred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
	To the within To the	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Month	
	0,		30. Name-and/address of person who completed cause of death (Item 23a) (Type, Print) and land		3/15/0	Ø 10
	10			Grene	ral XIV	pital
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 7 2006		,	

			riease	State of Ma					•	_	•
			For State	State of Ma	aryland		ent of Healti ate of Deal			211116	08132
			Registrar 1. Decedent's Name (First, Middle, La	et)		Certifica	ale of Dea		Date of Dea	Reg.(No.)	3. Time of Death
	Physici		CHARLOTTE P.	HALL					Month	Day 200	61512 am
	/Medic Examin		4a. Facility Name (If not institution, giv.		/	/ 4b. C	ity, Town, or Location	on of Death	juica	4c. County of D	eath
	LAdillii		Maryland G	eneral	14050	ital B	altimo/	e (1	ty		
	Funeral		5. Social Security Number 6. S	Sex 7. Age	e (In yr6. las	Month		der 24 Hrs. 8	Date of Birt	y, Year) 9. 8	Birthplace (State or Foreign Country)
	Director		216-42-4329	LIM 2/2NF (63	Yrs.			UNE 2,		MD
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Location					10d. Inside City Limits
	Marylan -f show lins at	ţ	MD			BALTIMO	DI				1√ Yes 2 □ No
	ith the M or 28a-f	Director	10e. Street and Number				Zip Code			10g. Citizen of What	Country?
	death with the Maryland ms 23a or 28a-f show mast to mallind at		1807 MORELAND A	VENUE			21216			USA	
	72 hours atter death w "natural", or items 23a tdeal Exameter must is	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was De If Yes, s	cedent of Hispanic pecify Cuban, Mex	Origin? (Speci ican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - A Black, W	mencan Indian, hite, etc.
38	s atte	by Fu	1 X Never Married 2 Marned 3 Widowed 4 Divorced	1 ☐ Yes 2 ☒↑ If Yes, Give Year or Dates:	No		s 2∏ No Spec			Specify:	BLACK
5-003	hour fural	ed b	15. Decedent's E			16a. Decedent's U	sual Occupation			16b. Kind of Busine	
~ —	iin 72 n nai	piet	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5		(Give kind of	work done during r Tuse retired)	nost of working	'		,
212	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12)	44		Н	OMEMAKER			HOME	
nd X	be file ta! Hy d oth	Be (17. Father's Name (First, Middle, Last,				18. M	other's Name (First, Middle,	Maiden Sumame)	
yla	2 should be filed and Menta! Hygid is marked other eumatic event, II.	မှ	JEROME P. HALL						ALLACE		
DR10+4.	s 1 and 2 should be filed within 72 hours alter death with the Maryla f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f ehov other treumatic event, the Medical Exameter Inter to confiled at		19a. Informant's Name/Relationship (EMMA W. HALL/MOT			-	•			or, City or Town, State $0., $	
(2)	s 1 and 2 of Health item 27 other tre		20a. Method of Disposition	TEK	20b. Pla	ce of Disposition (Vame of	Dat		20c. Location - City	
$\binom{\mathcal{N}}{\mathcal{B}^{altimore}}$	permit. Pages 'Department of Finportant: if ite eny injury or ot ance.		1 ☐ Burial 2 【☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			netery, crematory of RO CREMA		2/17/	06		
→	nit. Partme		21. Signature of Funeral Service Lices		PIEI			3/17/0		BALTIMORE,	SONS F.H., INC
Ba	permi Depar impo eny ir		Lames a	What	m					, MD 21217	
	5		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	00 /	1				rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Acus	le of	enal	Failu	re			Onset and Death
	/Medical		resulting in death)	Que to (or as	a conseque	enal nce of):	16		2 0		
8:	Examiner		Sequentially list conditions,	b. Conges			irt Fa	17/UK	e		
DX.	bed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to for as	a conseque	nce of):					
\	be executed icien and burial-transit	хап	that initiated events resulting in death) Last	cDue to (or as	a conseque	nce of):					
760,	sicien and burial-tra	calE	l	d							
289	The law requires that the death certilicate te has been signed by the attending physbage 2 should be detached for use as the	edic		u.							
Box 68	h cert endin	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1☐Live birth			pregnancy			23d. Date of	,
8.	ed for	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at						Month	Day Year
P.O.	d by ti	Phy	9 ☐ Unknown Part II. Other significant conditions of	contributing to doub b	upont rocult	ing in the underhild	s cours awas in D	ard I	23a Did to	phacco use contribute	e to the cause of death?
, S	restt signe d be d	þ	100000 RUA	A LAR 1	W 195011	In Se	ig cause given in F	ait i.			Probably 4 Minknown
, oc	requ been should	etec	11 .202 10 20	C/C/C/					-		/ ~
Rec	has a	Completed	HYPERTEIN	2/040					24a. Was autop perfo	rmed death	
<u> </u>	in: Th	e Co	25. Was case referred to medical				26 13	lace of Death (7	′es 2□No
5	Physician: this certitio	0 B	examiner?	Hospital:	ent 2 E	R/Outpatient 3	Othor			tence 6 ☐Other (S	ipecify)
Division of Vital Records,	ding Physician: The lav h. Atter this certilicete has funeral director, page 2	n: T	27. Manner of Death	28a. Date of Inju (Month, Da	rv 2	8b. Time of Injury	28c. Injury at Work?			now injury occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
io	endin sath. or: Att	atio	1 Datural 5 Pending investigatio	n	,	M	1 ☐ Yes 2	2 🗆 No			
.≅	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ury - At hom c. <i>(Specify)</i>	e, farm, street, fac	tory, office	28	If. Location (S City or Tox		Rural Route Number,
	pital o	i Ce	200 Continue of Continue Di		-6 (d d 1 - 15 -		
	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: Atter completely filled in by the funer	edicai	29a. Certifier (Check only one) 1 Certifying PI 2 Medical Example 1	nysician: To the best miner: On the basis of and manner sta	f examination	edge, death occur in and/or investigat	tion, in my opinion,	e and place, an death occurred	at the time,	date and place, and d	as stated. due to the cause(s)
	o the	Me	29b. Signature and title of certifier				29c. License numb	oer		29d. Date signed (Me	onth, Day, Year)
	- > F o		> (in)	DA. CHA	4NCU4	1. CINICAL	89.5	37		03/16/04	5
	1		30. Name and address of person who	completed gause of d	leath (Item 2	23a) (Type, Print)	22	/	0		Sospital
_			Chan chal	strigh 1	1/10	40 7	Mary.	land	Gil	nefal 1	LOSPITAL
8	Sta		31. Date filed (Month, Day, Year)	2 Aegistr	ar's Signatu	re					,
. X	Registi	air	MAR 1 7 200	6 Marcas	1 Ch	SADOME !					

			1 - For Amend Item# Registrer	206 per Hardand	3/22 Cer	riment of Healtl	h and Me th		ene 006	08133
	Physici	an	1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	MARVIN	a street and number)		- ICKS		MARCH	14 2006 4c. County of Deal	11:09 AM
	Examin Funeral Director	er	5. Social Security Number 6. S	opkins Hospit	st birthday). Yrs.	4b. City, Town, or Location Control of the Control	der 24 Hrs.	Date of Birth Month, Day, Y	MA	thplace (State or Foreign suntry)
	aryland •how	20	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits 1 ∰Yes 2 □ No
	vith the Mi	Directo	10e. Street and Number	-C112 A 1-	alt	MORE 10f. Zip Code		100	. Citizen of What Co	
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "naturel", or items 23s or 28s-f show event, the Madical Examiner must be notified at	Funeral Director	11. Marital Status 1 □ Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 292 No	13. V	Vas Decedent of Hispanic Yes, specify Cuban, Mex	Origin? (Spec	ify Yes or No- can, etc.)	14. Race - Ame Black, Whit	
-0036	Phours aft	by	3 Widowed 4 Divorced	If Yes, Give ' Year or Dates:	16a. Deced	Yes 2 No Spec		16	Specify:Blo	ack
21215-0036	d within 72 jiene. r then "na the Media	Completed	(Specify only highest gra		(Give	kind of work done during n OONOT use retired)	nost of working	, -	tome T	mornie ment
Maryland 2	uld be filed Aental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last,	Hicks		18. M	other's Name (First, Middle, Ma	anno	lauahn
	and 2 should Bath and Mer n 27 is marke		19a. Informant's Name/Relationship (Турө, Print) (Brother)	19b. Mailin	g Address (Street and Nu		d Dri	Dity or Town, State. 2	Zip Code) 21208
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other then "naturel, or Itema 23a or 28a-f ehow any injury or other traumatic event, the Madical Examiner must be notified at one.		20a. Method of Disposition 1 ☐ Burial 2 【ACremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	ce of Disponetery, crem	sition (Name of patory or other place)	3-24-(C. Location - City or	Town, State
Balti	permit. Departn Imports eny injt		21. Signatore of Funeral ServicerLicer		22	Name and Address of F Seph L. Rus 222 W. Nor	S Fun	eral H	ome, P. A	1216
			23a. Part Enter the disease, or com shock or heart failure. List only	plications that bacsed the death. one cause on each line.	Do not ente	er the mode of dying, such	as cardiac or	respiratory arres	t,	Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. SEPTIC Due to (or as a conseque		SHOCK				3days
	Examiner	ner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseque	rice of):					
o,	ficate be executed physiclen and is the burial-transit	I Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a conseque	nce of):					
38760,	physic s the br	dical	•	d						
Division of Vital Records, P.O. Box 6	To the Hospital or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificete has been signed by the ettending is completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
ds, P.	w requires that s been signed by should be deta	by Ph	Part ff. Other significant conditions of	1	-	, ,	art I.	23e. Did toba		the cause of death?
COL	w requ	letec	PANCREATI	E, HYPER		ENAL FALL		24a. Was an		utopsy findings available
tal Re	in: The la	e Completed by	11	g use 15M		NG		autopsy performe 1 Yes 2	d? prior to death?	completion of cause of 2 ☐ No
Ž	nysicie nis cert i direct	To Be	examiner? 1 ☐ Yes 2 No	Hospital: Inpatient 2 E	R/Outpatien	Other			ce 6 □Other (Spe	cify)
ion o	ending Plasth. Sath. Sr: After ti		27. Manner of Death 1	(Month, Day Year)	8b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2		d. Describe how	injury occurred	
DIX	To the Hospital or Attending Physicien: The lav within 24 hours after death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	building, etc. (Specify)				City or Town,		
	he Hosp n 24 hou he Funei bletely fil	edical	29a. Certifier Check only one) Certifier 2 Medical Example 2	nysician: To the best of my knowl niner: On the basis of examinatio and manner stated.	adge, daaith n and/or inv	estigation, in my opinion,	and place, an death occurred	d due to the cau I at the time, date	st(s) and manner as and place, and due	to the cause(s)
\ \	To ti To ti comp	ž	29b. Signature and title of certifier	a III		29c. License numb		290	. Date signed (Monti	
(1	Roshelle		n A	RES	-000	MA	arch 14	2006
/	0			CKWITH 600	NOF	LTH WOLF	E STR	EET B	ALTIMO	21287 RE MD
7.	Sta Registr		31. Date filed (Month, Day, Year) WAR 1 7 2006	32. Registrar's Signatu	Acare	E)				

			1 - State Amend Items	State of Marylan 29d,30 per Dr	d / Depa - , G85 /	irtmei	nt of H	ealth and i	Mental H	ygiene Reg. No	e 2 n n	for the same	081	31.
			Decedent's Name (First, Middle, Last)						2. Date of E	Death Da	. V	ear	3. Time of De	eath
	Physici /Medic		Khosrow Hamniaz						March		006	ear	4:00 F	PM M
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City	, Town, or	Location of Deat	h	40	. County of	Death		
			Holy Cross Hospit					Spring			ontgon			
	uneral		5. Social Security Number 6. Sex	M 2DE	last birthday) Yrs.	Months		If Under 24 Hrs. Hours Min.	(Month, I	Dey, Year,	,	Country		Foreign
D	irector		225-71-3512 'X	58			لــــــا		Ju1y	15, 1	947	Iran		
iand	M 18		10a. State 10b. County	10c. Cit	y, Town or Lo	cation	-					100	d. Inside City	Limits
Man	i de	ğ	MD Montgome	ry Be	thesda								1 ☐ Yes 2	XNo
th the	28. P. Tot	Director	10e. Street and Number			10f. Z	p Code			10g. Ci	tizen of Wha	at Countr	y?	unk
hours after death with the Maryland	23a	ai	10631 Weymouth St	reet #3	.,,,		20	814						
r dea	PE E	by Funerai		12. Was Decedent Ever in U. Armed Forces?	.S. 13. V	Was Deci	edent of Hi	spanic Origin? (S n, Mexican, Puer	pecify Yes or I to Rican, etc.)	No-	14. Race - Black,	American White, et		
s afte	0.0	Y.	1 Never Married 2 Married 3 ☑ Widowed 4 □ Divorced	1 ☐ Yes 2.∭ No If Yes, Give Year or Dates:	1	1 □ Yes	2 No	Specify:			Specify:	whi	te	
3 2	fural E E		15. Decedent's Educ		16a. Deced	ient's Us	ual Occupa	ation	unk	16b. F	(ind of Busin	ness/Indu	istry 1	unk
Maryland ZIZI3-0030 d 2 should be filed within 72 hours af	n "u	plet	(Specify only highest grade	completed)	(Give	kind of w	ork done d use retired	lurina most of wo	rking				,	
Media Media		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)										
2	vent,	Be C	17. Father's Name (First, Middle, Last)					18. Mother's Na			n Surname)			
d b	it c	၉	Abdula Hamniaz					Esmat S	hujaue	e 				
2 sho	ario Mentar nyterio. Is marked other than "natural", or lieme 23a or 28a-f show sumatic event, it a Madical Examinat must be notified at		19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. Mailin	ng Addres	s (Street a	and Number or Ru	ural Route Nun	nber, City	or Town, St	ate, Zip C	Code)	
2 g :	t: If Item 27 is marked y or other treumatics		Bertha Golkoski/f		_ 1060			th Stree	t #3 Be		da, Mi			
baltimore, bermit. Pages 1 ar	or ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	emetery, cren	natory or	other plac	e)	Date	20C. L	ocation - Ci	ty or row	m, State	
Pa	tant:		4 ☐ Donation 5 ☒ Other (Specify)											
	Important: If Its any Injury or of once.		21. Signatur of Funeral Service License Ronald S.	lade, Director	r St	ate	Anato	is of Facility Omy Boar MD_212		. Ba	ltimor	re St	reet	
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the deat	h. Do not ent	er the mo	de of dyin	g, such as cardia	c or respiratory	arrest,		1	Approximate nterval Betwe	en
Phy	ysician		Immediate Cause (Final disease or condition	Hemoptysis	3							- 1	Onset and De	ath
	fedical		resulting in death)	Due to (or as a conseq										
EX	aminer		Sequentially list conditions,	sersis								_		
þ	# tis	ine	tany, leading to in models cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons⊛)	neuce of									
xecut	and Il-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):							-		
8 f o U, sate be executed	physicien and is the burial-transit	ie H												
OO /	physis the	edicai												
-	attending p for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna		Tetonio	0.00.00.00.00.00.00.00.00.00.00.00.00.0				23d. Date	of delivery	4	
deat o	e atte	icia	in the past 12 months? 1 \(\sum \) Yes 2 \(\sum \) No	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown		Other (pregnancy specify)			-	Month		Day Ye	ar
) å	ed by the detached	hys	9 🗆 Unknown	9LI Unknown										
s t	500	b	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the u	nderlying	cause give	en in Part I.			1		cause of dea	
	been si	ted	H/O tuberculosis						11	∐Yes 2	No 3	Proba	bly 4 □Unl	known
§ ©	S C/	Completed	arthritis. anemi	.a 					24a. W	topsy	pric	or to com	sy findings av pletion of cau	railable use of
ב פ <u>פ</u>	page	် ၁	_						pe 1 ☐ Yes	rformed?		ath? Yes 2	. ₽No	
VITE	ector	Be	25. Was case referred to medical examiner?	lospital:			Oth	26. Place of De						
UIVISION OT VITAI RECOIDS, P.O. BOX i or Attending Physician: The lew requires that the death cer	this o	٦.	1 Yes 2 No	28a. Date of Injury	ER/Outpatier 28b. Time of			4 Li Nursing i	dome 5 ☐ Re					
ding.	After funer	E G	1 Natural 5 Pending	(Month, Day Year)	Injury	м	28c, Injun Worl	k? Yes 2 □ No	20d. Describ	o now mg	ary occurred	'		
VISION OF VITAL	ctor: y the	fica	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, str							or Rural	Route Numbe	ar,
	s arrer al Dire ed in b	Certification;	4 Homicide	building, etc. (Special	fy)				City or	Town, Sta	fe)			
Hosp!	within 24 hours after death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page	Medical		sician: To the best of my kno ner: On the basis of examina and manner stated.										
To th	To the	Me	29b. Signature and title of certifier			2	9c. Licens	e number			ate signed (
•			1 (shama	Crery			D 6	0826		Marc	ch 7,	2006		
			20 Name and address of person who of	mpleted cause of death (Ites	п 23а) (Туре,	Print)			210					
			Kshama Garg, M.D.			KOAd	, 5.5	., MD ZU:						
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 1 7 2006	32. Registrar's Signa	ature	No. B								

ORIGINAL

960€

			For state	State of Marylar		artment of F			giene	nns	0813	5
*			Registrar 1. Decedent's Name (First, Middle, La	st)		Timouto or		2. Date of De	ath	000	3. Time of De	ath
	ysicia		Charles	Rex Hel	lmann			Month March	Day	006	8:30 A	М
	Medic amin		4a. Facility Name (If not institution, giv		Timerini	4b. City, Town, o	r Location of De		7	County of Dea		1
	.a.iiiii		4709 Chevy Chase	Bouleward		Chevy (Chase		Mo	ntgome	ry	
Fun	eral		5. Social Security Number 6. S	iex 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days		rs. 8. Date of Bir			thplace (State or Fountry)	oreign
Dire			220-18-4223	M 2□F 80	Yrs.	Months Days	Hours Mi	rs. 8. Date of Bir (Month, Da October	22 , 19	25 Mar	yland	
pu ,			Usual Residence of Decedent	10- 6	ty, Town or Lo						10d. Inside City L	limite
aryla shov	10	_	10a. State 10b. County		,						1 Tyes 2	
8a-1	office	Sct	Maryland Montg	omery C	hevy C				10 000			
with ti	De D	声	10e. Street and Number 4709 Chevy Chase	Dland		10f. Zip Code 2081	15			en of What Co ed Sta		
ING Z I Z I 3-UU30 be filed within 72 hours after death with the Maryland tal hygiene. It other than "natural", or Itams 23a or 28a-f show	resst	Funeral Directo		12. Was Decedent Ever in U	19 13			(Specify Ves or No		4. Race - Ame		
ter de	786	Ğ.	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Amed Forces?	43-	If Yes, specify Cub	an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	,	Black, Whit		
rs aff	Marri	by F	3 Widowed 4 Divorced	If Yes, Give	46	1 ☐ Yes 2 🔯 No	Specify:			Specify: Wh	ite	
D-UUSO 72 hours af natural', or	33		15. Decedent's E	ducation	16a, Dece	dent's Usual Occup	pation		16b. Kin	d of Business		
6. Brin 73 Brin 100	Mad	Pe	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	life.	kind of work done DO NOT use retire	during most of w d)	vorking .				
d with	100	Completed	Elementary, Secondary (6 12)	4	Arc	hitect			Fed	eral G	overnment	t
id be file lental Hy ked othe	vent	Bec	17. Father's Name (First, Middle, Last,)			18. Mother's N	lame (First, Middle	, Maiden S	Sumame)		
uid b Menta	e c	2	Cyril R. Hellman	n			Mildr	ed McKen	zie			
Daltimore, Maryland 21215-0050 permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 271s marked other than "natural", or Itams 23s or 28s-1 show	aume		19a. Informant's Name/Relationship (Type, Print)	1.	•		Rural Route Numb				
and 2	er tra		Rose Marie Hellm		All constructions			d., Chevy				815
of He	t f		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	20b. I	Place of Dispo cometery, cre	osition (Name of matory or other pla		ch 16,		ation - City or		
SAITIMO Dermit. Pages Department of Mportant: If it	o Arr		4 □ Donation 5 □ Other (Specif		tgomery	Crematoriu	m, Inc 2	2006	Beth	esda, 1	Maryland	
rmit.	eny inj		21. Signature of Funeral Service Licen	3500	$R_{\rm C}^2$	2. Name and Addre	ss of Facility Tohrey Fu	neral Home/	Bethe	sda-Chev	v Chase, In	ıc.
n gae	≅ 8		Ungelette De	ne ist MOI	305 75	57 Wiscons	in Avenue,	, Bethesda,	Mary1	and 2081	4-3501	
			23a. Part1. Epter the disease, or com shock, or heart failure. List only	plications that caused the dea	th. Do not en	ter the mode of dyir	ng, such as card	liac or respiratory a	rrest,		Approximate Interval Between	
Physic	cian		Immediate Cause (Final disease or condition	. Severe Chr	onic O	bstructiv	ze Pulmo	narv Dis	ease		Onset and Dea 2 Years	ith
/Med			resulting in death)	Due to (or as a consec								
Exam	iner	-	Sequentially list conditions	Long Term	Smokin	g History	7				40 Years	3
) / D	. 	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):							
of the po	trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
ate be executed hysician and	urial		resulting in death) cast	Due to (or as a consec	quence of):							
ate b	the b	lical		d								
. BOX BB / death certificate e attending phys	9 98	Physician/Med	IF FEMALE:									
BOX auth cer attendir	or us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1☐Live birth 2☐Feta	aldeath 3	Ectopic pregnanc	y		2	3d. Date of de Month	livery Day Yea	ir
the a	ped t	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of a 9☐ Unknown	death 5	Other (specify) _					,	
COLDS, P.O. BOX OR **requires that the death certificate been signed by the attending pt	Jetac		Part II. Other significant conditions	contributing to death but not re-	sulting in the u	inderlying cause giv	en in Part I	23e. Did	tobacco us	se contribute to	the cause of deat	th?
IS, ires t signe	P P	l by	, 		3	,					robably 4 Unk	
COTOS w requires been sign	houl	Completed						-				
as a co	9 2 8	dr						24a. Was		prior to death?	utopsy findings ava completion of caus	se of
at at	. page							1 ☐ Yes	2 🕅 No	1 🗆 Yes	2 □ No	
OT VITAL P Physician: Th rthis certificate	ecto	Be	25. Was case referred to medical examiner?	Hospital:		0#		Death (Check only				
Phys	aldi	<u>1</u>	1 ☐ Yes 2 📉 No 27. Manner of Death	1 Inpatient 2	ER/Outpatie	III JU DON	- 14013111g	g Home 5 Resi			ecify)	
Affer and	fune	5	1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	Wo	rk? Yes 2 □ No	254. 2555.155		55541155		
UIVISION Of all or Attending Parties after death.	the /	Certification:	3 Suicide 6 Could not b	OB Place of laiunt. At h	ome farm st			28f. Location /	Street and	Number or R	ural Route Number	f.
Oly after Dire	i d	ertii	4 Homicide determined	building, etc. (Speci	fy)	reel reelely; eller			wn, State)			
To the Hospital or within 24 hours af To the Funeral D	completely filled in by the funeral director.		29a, Certifier 1 X Certifying PI	hysician: To the best of my kn	owledge, deal	th occurred at the ti	me, date and nia	ace, and due to the	cause(s)	and manner a	s stated.	
24 h	etely	edical	(Check only 2 Medical Examone)	miner: On the basis of examination	ation and/or in	ivestigation, in my	opinion, death of	courred at the time,	date and	place, and du	e to the cause(s)	
o the	ldmo	Me	29b. Signature and little of certifier			29c. Licens	se number		29d. Date	signed (Mon	th. Day, Year)	
- 5 -	5		10/			D00)53711		Marc	h 16,	2006	
_A V	\		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type							
87	-		Pasquale Santini				, Chevy	Chase, M	ary1a	nd 208	15-4302	
	Sta	te	31. Date filed (Month Pay, Year)	32 Registrar's Sign	ature	Carles o						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 10:48 P M Nancy Griffin Hogarth March 11 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Harford Havre de Grace 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 M 2 N F Yrs 214-34-4056 5, 1933 Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Jarrettsville Maryland Harford 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3861 Old Federal Hill Road 21084 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes ZXXNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Griffin Clyde Sylvester Flora Foreman Lipe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) -Husband 3861 Old Federal Hill Rd., Jarrettsville, MD 21084 Edward L. Hogarth, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp. 3/17/06 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. (ussell 50 West Broadway Street, Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) theumen aaus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivers 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an autopsy performed? Yes 2 - No 1 ☐ Yes

Priysician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

5 23a

ltems.

permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iten any injury or other traumatic event, Ite Marical Exercit et once.

Baltimore, Maryland 21215-0036

Director

Funeral

ģ

Completed

Be

ပ

the Maryland

burial-transit and attending physician for use as the buria detached peen page 2 certificate has

Box 68760, P.O. After this Division or Attending death. Director: within 24 hours after To the Funeral Direct Hospital

Examine Physician/Medicai by Completed 2 Certification:

DHMH 17 Rev 1/2001

State Registrar

cai

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) south 31. Date filed (Month, Day, Year)

5 Pending

investigation

6 Could not be determined

25. Was case referred to medical examiner?

29b. Signature and title of certifier

1 ☐ Yes 2 ☐ No

27. Mann of Death

1 Natural

3 ☐ Suicide

29a. Certifier

2 Accident

4 - Homicide

(Check only

venue 32. Registrar's Signature

Hospital: 1 I Impatient

28a. Date of Injury (Month, Day Year)

ORIGINAL

2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

3 DOA

28c. Injury at Work?

1 [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Tyes

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

26. Place of Death (Check only one)

2 🗌 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 4 2<u>006</u> Month **Physician** March 14 10:40 AM RICHARD WILLIAM HARPER /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Greater Baltimore Medical Towson Hours Min. B. Date of Birth (Month, Day, Year) DEC. 7,1932 PENNSYLVANIA If Under 1 Year Months Days 5. Social Security Number 6. Sex_ 1 Z M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Yrs. 218-28-7064 73 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show other than "natural", or iteme 23a or 28a-f sho vent, the Madical Examiner must be notified at 1 Nes 2 No Director WORCHESTER OCEAN CITY MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13 131st. 201 21842 APT U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ∑ Yes 2 □ No
If Yes, Give 1 0 □ 0 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: þ 3 ₩ Widowed 4 Divorced Year or Dates: 1950 – 53 WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) GENERAL MANAGER WESTINGHOUSE 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be Pages 1 and 2 should be trained of Heelth and Mentatent: If item 27 is marked is marked WILLIAM FRANKLIN FOX ELIZABETH EMILY SPOTTS 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JACQUELINE MATASSA/DAUGHTER 234 ASTER LANE, FOREST HILL, MD. 21050 other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If any injury or once. BAYVIEW CREMATORY 3/15/06 BALTIMORE, MARYLAND 22. Name and Address of Facility
LILLY & ZEILER INC. FUNERAL HOME
700 S. CONKLING STREET, BALTIMORE, MD. 21224 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or a p consequence of): Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□ Pregnant at time of death 5 Other (specify) P.O. I Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, cete hes been sign, , page 2 should be 3 Probably 4 Unknown 1 Yes 2 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 20 No 1☐ Yes 1 Tyes 20 Physicien: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 1 Tes 2 ER/Outpatient 3 DOA this After this funeral o Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division l or Attending 1 Natural 2 Accident 5 Pending after death.

Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. within 2 29d. D. te signed (Month, Day, Year) 29b. Signatu 29c. License number 104 2. Registrar's Signature 7 2005 Registrar

			For	State of Ma	ryland / Depa				0.0	() ("	00120
			Registrar		Ce	rtificate of L	Jeath		eg. No. 🥠	UU	00130
	Physicia	an	Decedent's Name (First, Middle, Lass	John	0.	Helfrich		2. Date of Dear Month March	Day	Year	3. Time of Death 5:45 P
•	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death			ty of Death	J:45 F
	LAGITIII	EI	8121 Longpoint F	oad.		Dunda	1 k			Balt:	imore
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	Year)	9. Birthp	place (State or Foreign
	Director		217-12-9105	ฐ _{M 2□} F 81	Yrs.	Worth's Day's	710013	March 2	26,1924		yland
þ	₹ 8saY		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				1	10d. Inside City Limits
lave	e how	5	,								1 ☐ Yes 2 🗓 No
A ed	28a-f	Director	Maryland Ba	ltimore		10f. Zip Code	lalk	1	0g. Citizen of	What Cou	ntry?
<u>\$</u>	0 9		8121 Longpoint	Pond		10.1 2.1 0000	21222			ed Sta	
deeth	The 2;	Funeral	11. Marital Status	12. Was Decedent E	iver in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		pecify Yes or No-	14. Ra	ce - Americ	can Indian,
o die	a a	큔	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No	0			Rican, etc.)		ack, White,	etc.
III Z I Z I 3-0030	Fig	1 by	3 ⊠ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Speci	wh	nite
2 4 2	natu	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occupa kind of work done of	furing most of work	king	16b. Kind of I		•
1 i	hen bem	ᇤ	Elementary/Secondary (0-12)	College (1-4or 5-	+)	DO NOT use retired	,		Baltin		-
7 6	Hygie ther nt, tr		12 Years 17. Father's Name (First, Middle, Last)		PC	olice Off:	18. Mother's Nam	ne (First, Middle,			rtment
	o per c	o Be	Anthony Helfr				Addie			, 01	211.
Y	mari mati	ို	19a. Informant's Name/Relationship		ter 19b. Maili	ng Address (Street a		ral Route Number	r, City or Town	n, State, Zip	Code)
Ma 2	27 is		Joyce Ann Helfri			Acorn Circ	cle Apt.	202 Tov	wson, N	Maryla	and 21286
5 5	Item othe		20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other place	e)	Date	20c. Location	- City or To	own, State
	int: If		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	-	1	Valley Mer		3/17/200	06 Tir	noniun	n, MD
AILITION OF THE PAGE S	Department of Heelth and Mental Hygiene. Important: If item 27 is marked other then "naturel", or iteme 23s or 28s-f ehow eny injury or other treumatic event, the Modical Examinar must be inclined at once.		21. Signature of Funeral Service Licen	9 ⁹⁹ 0 0	/ 2 Di	2. Name and Addres	s of Facility	- Home of I	Dundall	c. Inc	7.
0 8	88328		mobile	1 Thurs	1 7	922 Wise	Ave. Du	ndalk, M	Marylar		222
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each line	the death. Do not en e.	ter the mode of dyin	g, such as cardiac	or respiratory arr	est,		Approximate Interval Between
P	hysician		Immediate Cause (Final disease or condition	I Isc	hemic c	ardioni	woodh	λ			Onset and Death
	Medical xaminer		resulting in death)	Due to (or as a	consequence of):		11)	-		1)
	Adminici	L.	Sequentially list conditions,	b. Dun to for as a	consequence of):						many years
10	ısıt	ulue	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence or).						
, O	al-tra	Examiner	that initiated events resulting in death) Last	CDue to (or as a	consequence of):			<u> </u>			
o / oU,	physicien and the burial-transit	dical		d							
Geath cedificate be	ng ph) as th	led	15.55141.5								
X of	endir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		☐Ectopic pregnancy				ate of deliv	*
	the at	Physiclan/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at t 9☐ Unknown		Other (specify)			IV	fonth	Day Year
7. 4	d by letach	P.	Part II. Other significant conditions of	contributing to death bu	at not resulting in the	inderhina cauce and	an in Part I	23e Did to	hacco use co	ntribute to t	he cause of death?
S D	signe d be d	Completed by	01:	ical cov	D OXITALU	CiC	or are are a		es 2□No	2 Prol	
	been	etec	17 21 17 17 20	11.10	a forest	· · · · · ·		24a. Was a	24h	-	opsy findings available
	s hes	dm	1011217111	utalla	thyroid	(2M)		autop: perfor	med2	prior to co death?	empletion of cause of
VII CIN	ificete or, pa	e Cc	25. Was case referred to medical				26 Place of Dea	1 ☐ Yes	2/2/No	1 🗆 Yes	2∐ No
>	s cert direct	To B	examiner?	Hospital: 1 ☐ Inpatier	nt 2□ER/Outpatie	nt 3 DOA Oth			ence 6 □C	ther (Specia	(v)
0 8	erthii eralo		27. Manner of Death	28a. Date of Injury (Month, Day	y 28b. Time o			28d. Describe h			
0	ath. Pr: Aft	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	n	, car,		Yes 2 □ No				
DIVISION OF	recto	ertification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ry - At home, farm, st . (Specify)	reet, factory, office		28f. Location (S City or Tow	treet and Nun n, State)	nber or Rur	al Route Number,
ב ב	re in the life of	O	THE SEA								
i i	within 24 hours effer death. To the Funare! Director: Affer this certificete has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier Certifying Ph (Check only 2 Medical Exer	niner: On the basis of	examination and/or in	th occurred at the tin evestigation, in my o	ne, date and place pinion, death occu	, and due to the or rred at the time, o	ause(s) and r late and place	nanner as s a, and due t	stated. o the cause(s)
t t	ithin of the comple	Mec	29b. Signature and title of certifier	and manner stat	Ted.	29c. License	e number		29d. Date sigr	ned (Month,	Day, Year)
i [†]	ŏ⊢ĕ		11	12.0-	Low	N-	78137		311	5/0	6
	/		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type		sard 5	Freeko	anti		
	5		5601 Loch Rai	1	. Bull	rimore 1	US 313	139			
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	- M -					
3	Registr	rar	MAR 1 7 20	006 Dec	S 15 15						

HELEN C. HOLEWINSKI 06-01826 RKD

			1 - For State Registrar	State of Ma	aryland / Dep	artment of F		Mental H	ygiene Reg. No.	2001	5 08130
	- N		1. Decedent's Name (First, Middle, Last)				2. Date of D	eath Day	y Ye	3. Time of Death
4	Physici /Medio		Hele	en C.	Hole	winski		MARCH	14		
1	Examir		4a. Facility Name (If not institution, give			4b. City, Town, o		ath		County of D	
			5. Social Security Number 6. Se		/la usa last histhda	DUNDAL	If Under 24 H	rs 9 Data of D		LTIMO	
	Funeral Director			TM 213-F	83 Yrs.	Months Days	Hours Mi				Birthplace (State or Foreign Country) Maryland
	yland Now		10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
	Mar	to	Maryland Balti	imore			Dunc	dalk			1 ☐ Yes ¾ŢNo
	or 28	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citi	izen of What	t Country?
	23a	rai	6817 Brentwood Av	7e.			21222		Uni	ted S	tates
	ar den	une	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? an, Mexican, Pue	(Specify Yes or N erto Rican, etc.)	0-		American Indian, Vhite, etc.
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	10	1 ☐ Yes 2 ☑ No	Specify:			Specify:	
8	n 72 hours after deeth with the Maryland "naturel", or frema 23a or 28a-f ehow salcal Ezaminer must be notified at	ed	15. Decedent's Edu	ıcation	16a. Deci	edent's Usual Occup	ation		16b. Ki	ind of Busine	White ess/industry
215	_ 1 33	plet	(Specify only highest grad	le completed) College (1-4or 5-	(Giv	e kind of work done DO NOT use retired	during most of w	rorking			,
21	TI (0) 10 10 10 10 10 10 10 10 10 10 10 10 10	Completed	7 Years		· .	actory Wo	rker		Am	erica	n Can Co.
Б	be filed ital Hygi d other event, I	Be (17. Father's Name (First, Middle, Last)					ame (First, Middl		Sumame)	
yla		ပ	Benjamin Ciesie				Teof	ila Maye	eski		
Maryland 21215-0036	s 1 and 2 should f Heelth and Mer frem 27 is marke other treumatic		19a. Informant's Name/Relationship (T) Diana M. Ches (Da	ype, Print) aughter)		ing Address <i>(Str</i> ee <i>t</i> Liberty S					
	1 and Heelth		20a. Method of Disposition		20b. Place of Disp		. West	minster,	-		21157
Baltimore,	0 = 0		1 Burial 2 Cremation 3 F		cemetery, cre	matory or other plac	1				
Ē	in transfer		4 □ Donation 5 □ Other (Specify) 21. Signature of Peneral Service License	Entombment		Valley M 2. Name and Addre	em. Gdns	s.3/18/2	006	Timon	ium, Maryland
Ba	Deperiment of the period of th		hall 11	Vyn	1/1///	Duda-Ruck	Funeral	l Home of	E Dun	dalk,	Inc.
			23a. Part1. Enter the disease, or compl	lications that caused	the death. Do not er	922 Wise				and	Approximate
	Physician		shock, or heart failure. List only o Immediate Cause (Final			molication	. 1	1			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a	a consequence of):	Adriac ch	9 thype	v tensiv	CUDO	- Dream	200
ш	Examiner		Sequentially list conditions	b		(FICE OSC !-	0,0,00	aracovas	, com	~ 17 Sec	45
12	4o =	ner	if any, leading to immediate cause. Enter Underlying		a consequence of):						
10	ecute and trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c							
8760,	ate be executed hysicien and the burial-transit		Toodking in Godkin East	Due to (or as a	a consequence of);						
387	physi physi the t	dicai	•	d							
39 X	death certificat e attending phy id for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome of	of pregnancy					23d. Date of	delivery
Вох	atter of for u	ciar	in the past 12 months?	1 ☐ Live birth : 4 ☐ Pregnant at	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	'		1	Month	Day Year
0	0 0 2	hysi	1 U Yes 2 WNo 9 □ Unknown	9□ Unknown							
۳.	The law requires that the ste hes been signed by the page 2 should be detache	by PI	Part II. Other significant conditions con	ntributing to death bu	it not resulting in the	underlying cause giv	en in Part I.	23e. Did	tobacco u	se contribut	e to the cause of death?
Records,	w require been sig should b							10	Yes 2	Divo 3□	Probably 4 Unknown
သို့	e law requ hes been je 2 shoul	piet						24a. Wa	s an opsy		autopsy findings available
Ě		Completed						per 1 X Yes	formed?	death	
of Vital	Physicien: Th r this certificete ral director, pag	Be	25. Was case referred to medical examiner?				26. Place of D	eath (Check only		1 1	
<u>~</u>	Physic this co	ျှ	1XXYes 2□No	lospital: 1 ☐ Inpatier			4 🗀 Nursing				Specify) SCENE
Ē	Ing P	i o	27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Injury	Year) Injury,	Wor	y at k?	28d. Describe	how injury	y occurred	
isio	Attending r death.	cat	2 Accident investigation 3 Suicide 6 Could not be		11.36	7	Yes 2 XVo	204 1	(611	d A1	0 10 11
-	i or Attenation after deati	Certification;	4 Homicide determined	building: etc	iry - At home, farm, si . (Specify) 	•		City or To	own, State,	Prohal	r Rural Route Number, Me fall from
_	spital ours nerel filled	<u>a</u>	29a. Certifier 1 ☐ Certifying Phy	sician: To the best o			ne, date and plac		duing	1100	
	To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai		ner: On the basis of and manner stat	examination and/or in	vestigation, in my o	pinion, death oc	curred at the time	, date and	place, and	due to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier		_	29c. Licens	e number		29d. Dat	e signed (M	ionth, Day, Year)
)			Draft,	allan	_ md	0.C.	м.Е.		MARCI	Н 15,	2007
	3		30. Name and address of person who co	mpleted cause of de	eath (Item 23a) Type		COD TITE	DATES		AD17- 4	D 01001
			21 Date filed (Heath Day Van)	MAN	wo,	111 PENN	STREET	RALTIMOR	E, M	ARYLAN	D 21201
7.	Sta Registr		31. Date filed (Month, Day, Year) MAR I 7 2003	Sz. Hegistra	r's Signature	10					

			For State		_				d Mental Hy	giene	-70	
	¥ (e.)		1. Decedent's Name (First, Middle, La	#26 Per	PHY G8	353 3/9	7/166 tent	Death	2. Date of De.	Reg. No.	6	08140
¥	Physici	an	T, Decedent's Name (First, Middle, La		c Fdwa	rd Hali	1		Month	Day	Year	3. Time of Death
1	/Medic Examir		4a. Facility Name (If not institution, giv			La Hai.		or Location of De	March	12, 200 4c. County		6:00 A'''
Aug.	LXdiiii	் .	105 Brinsmaid Co	ourt				sedale				ce Co.
	Funeral		Social Security Number 6. S	ex	7. Age (In yrs.	. last birthday)	If Under 1 Year Months Days	If Under 24 h	Hrs. 8. Date of Bird Month, Da	th		lace (State or Foreign
40	Director		219-01-9220 Usual Residence of Decedent	M 2□F	85	Yrs.				20,1921		land
	ow a		10a. State 10b. County		10c. C	ity, Town or Lo	cation				1	0d. Inside City Limits
	Mary a-f eh	tor	Alabama Madisor	ì			ī	Huntsvil	10			1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number				10f. Zip Code	IUIICSVII		10g. Citizen of V	What Cour	itry?
	ath w	rai	10013 Camille Di					35803		United		
	tems thems	Funerai	11. Marital Status	12. Was Dece	ces?	J.S. 13. \	Was Decedent of Yes, specify Cub	Hispanic Origin? pan, Mexican, Pu	(Specify Yes or No Jerto Rican, etc.)	- 14. Rac Blac	e - Americ k, White,	an Indian, etc.
336	urs aft	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes If Yes, Give Year or Da	TATTAT T	I	I□Yes 2ŽNo	Specify:		Specify	·: V	Mhite
21215-0036	within 72 hours after death with the Maryland ane. Ithan "naturel", or items 23a or 28a-f ehow Ita Marical Eas cilier front be rediffed at	ted	15. Decedent's Ed (Specify only highest gra			16a. Deced	lent's Usual Occu	pation		16b. Kind of Bu	ısıness/Inc	dustry
2	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)	life. L	kind of work done DO NOT use retire	ed)	working			
	iled w tygier ther th	Cor	17. Father's Name (First, Middle, Last)	Years		Aer	rospace I					artin Corp.
and	d be f	Be c							Name (First, Middle,		10)	
Maryland	Shoule nd Me mark mati	ဥ	Francis V. Hall 19a. Informant's Name/Relationship			19b. Mailin	a Address (Stree	-	ly Piasec		State Zin	Codel
	alth a		Janet A. Chester	(Niec	e)		Brinsma		Rosedale,			21237
ore,	of He of He rothe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Domeus I from S		Place of Dispo	sition (Name of natory or other pla	ice)	Date	20c. Location -	City or To	wn, State
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or items 23a or 28a-f show amy injury or other traumatic event, the Marical Examinational National Progress.		4 Donation 5 Other (Specify			acred F	it. Of Je	esus Cem	. 3/16/20	06 Dun	dalk,	MD
Ball	permit Depart Import Import In in		21. Senature of Funeral Service Licer	SO)		7) 22	Name and Addre	ess of Facility Tunera	l Home of	Dundal	k. Tr	ıc.
70.00	40.2 6 0	6	23a. Part1 Enter the disease, or com	plications (SO) on	ass	\angle \perp 7	922 Wise	Ave.	Dundalk,	Maryland	21	222
12	A A		shock, or heart failure. List only Immediate Cause (Final	one cause on ea	ich line.	un. 50 not ent	ar the mode of dy	ng, such as card	nac or respiratory ar	rest,		Approximate Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	a. /V p	or as a consec	au (iell	Ling	Cari	cinom	9	5 MHS.
	Examiner		Conversible line and distant	, 50	3 ~ ~		oid to	De 11 OF	cell	Carcin	01110	1 MH/
	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (d	or as a consec		0) - (0-	TVU	Cert	JU CIT	UPTG	1115
H	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to /c								
8760,	icate be executed physician and s the burial-transit	ai E	, , , , , , , , , , , , , , , , , , , ,	Due to (t	or as a consec	trieuce or):						
687		edicai		d								
Вох	death certifi e attending d for use as	N/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc			le			23d. Dat	e of delive	ry
	0 0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		nth 2 ☐ Feta ant at time of o		Ectopic pregnanc Other (specify) _	у		Moi		Day Year
о. О	that the de led by the a detached t	Phys	9 Unknown						<u> </u>			
Ś	Se G	þ	Part II. Other significant conditions of	ontributing to dea	ath but not res	,		ven in Part I.				e cause of death?
Records,	w require been si should b	Completed	Pappi	2004	e	400	11800		- 1 Y			ably 4 Unknown
Rec	: The law cate has t page 2 s	mpi							- 24a. Was autop	an 24b. V	Vere autor prior to con leath?	osy findings available npletion of cause of
	ician: Th certificate rector, paç	e Co	25. Was case referred to medical					00 00 45	1 ☐ Yes	2 No 1	Yes	2 ☐ No
>	ysicia s cert direct	0 8	examiner?	Hospital:	patient 2	ER/Outpatien	3 DOA 0#	100	Death (Check only of		ar (Canada	Niece's Home
0	19 Ph ter th	T: L	27. Manner of Death	28a. Date o		28b. Time of Injury	28c. Inju			ow injury occurr		nome
<u>0</u>	endir eath. or: Af	atic	1 Natural 5 Pending 2 Accident Investigation		, 00, 100,	Jory		Yes 2 □ No				
Division of	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	288. Ptace (of Injury - At h g, etc. <i>(Sp</i> eci	ome, farm, stre fy)	et, factory, office		281. Location (S City or Tow	treet and Numbern, State)	er or Rura	Route Number,
	pital ours a erai C		29a. Certifier 12 Certifying Ph	veicies: To the i	and of my kn	audadaa daath						
	• Hos	Medical	(Check only 2 Medical Exam	niner: On the ba	sis of examina	ation and/or inv	estigation, in my	me, date and pla opinion, death of	ace, and due to the occurred at the time, o	date and place, a	nner as st and due to	ated. the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: Alter this certifical completely filled in by the funeral director;	Me	29b. Signature and title of certifier		(Im		29c. Licens	se number		29d. Date signed	(Month, I	Day, Year)
			DR-JOHN	C0#	X		H	3550	73	3/13	10.6	
I	6+1		30. Name and address of person who	completed cause	of death (Iter	m 23a) (Type, I	27	Á	0.1	-	AAV	20.02
1			31. Date filed (Month, Day, Year)	32/120	gistrar's Signa	124	Mac	me.	, natin	are 1	IVI	21221
	Sta Registr	_	MAR 1 7 20	06	_	K Loa	dis					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician Harding 8:31p FVVE OF /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Meduco l Cente 4~~ Anna Polus If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2□ F 22956193 Virginia Director 117143 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or items 23s or 28s-f ehow the Madical Examiner must be notified at 1 Yes 2 No Mitchellville Director Prince Georges Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20721 13200 Bermondsey Ct. 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status be filed within 72 hours after de tal Hygiene. d other than "natural", or item: 1 Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Training Officer permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: if Item 27 is marked other ith eny injury or other treumatic event, ILS once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mildred Smith Arthur McKinley Harding, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13200 Bermondsey Ct. Mitchellville, Md. Annie E. Harding / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/4/2006 Suitland, Md. Cedar Hill 21. Signature of Funeral Service Ligensee Name and Address of Facility one Funeral Homes, P.A. M0108 5538 Marlboro Pike/Forestville, Md. 23a. Part1. Ehter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20747 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Myocardul Infavation /Medical Due to (or as a consequence of) Examiner complications if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last signed by the attending physicien and doe detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 1 Yes 28 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient s after death.
I Director: After this
of in by the funeral d 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funaral L To the Hospital 10 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the eauss(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0055921 wuse of death (Item 23a) (Type, Print) 30. Name and address of person who comspeciale 2001 Medical Park Way; Annapolis, MD. 21401

1- 12 DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

M.D.

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Year Physician 15, MARCH 2006 4:44 Μ. JACKSON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MARYLAND GENERAL HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🛛 F Yrs. AUGUST 19,1933 MD Director 216-74-4474 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10b. County 10c. City. Town or Location 28a-f show the Medical Examiner must be notified at 1XXYes 2 ☐ No BALTIMORE MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or USA 21201 1100 PENNSYLVANIA AVENUE APT 907 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. ģ 3 XWidowed 4 □ Divorced BLACK "neturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) HOUSEWORK DOMESTIC 11 .. Pages 1 and 2 should be filed v tment of Health and Mental Hygie tent: If item 27 is marked other t jury or other treumatic event, In 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) NELLIE BRYANT ARTHUR JENKINS SHARP 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 110 N. CENTRAL AVE. APT 315 BALTIMORE MD 21202 OLIVIA COLLIER/SISTER Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department o Importent: If eny injury or once. 4 ☐Donation 5 ☐ Other (Specify) ZION CEMETERY 3-21-2006 BALTIMORE, MARYLAND MT. 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signature of Funeral Service Licensee 1701-31 LAURENS ST. BALTIMORE, MARYLAND 21217 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tipe. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Du /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examiner The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760, discin by Physician/Medical the as signed by the ettending the detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ N O 9 Unknown 9 Unknown Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Minknown Militia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No certificate 1 Yes Division of Vital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ۵ this After thi 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28d. Describe how injury occurred 28b. Time of 28c. Certification: Injury 1 Whatural 5 Pending 1 Tes 2 No death. investigation 2 Accident within 24 hours after death

To the Funerel Director:
completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel to the cause (s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number oun w 3 cerson who completed cause of death (Item 23a) (Type, Print) 30. Name and address row 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 7 2006

			For State Registrar		State of M	arylan	-			ealth a	and M	ental H	ygien Rag N	-0.06		811	3
2019 12			1. Decedent's Name (First, M	ddle, Last)								2. Date of D Month		ay \	/ear	3. Time of	
Na.	Physici /Medic		Rosie	Jul	nson							03		5 0) (15.5	5 PM
)	Examin		4a. Facility Name (If not institu	ition, give s	treet and number	}				Location (of Death		40	c. County of		1	
\$				lursia		me	last birthday)		r 1 Year	If Under	24 Hrs	9. Data of F	lieth		G WG N		- Caraina
	Funeral		5. Social Security Number	6. Sex	M 200 F	7 5	Yrs.	Months		Hours	Min.	8. Date of E	Day, Year	120	Coun	ace (State of	Foreign ▶
**	Director		Usual Residence of Deceden			00						6 91	<i></i>	140		1-9	
	s show	lor	10a. State 10b. Cou		nore	1 1 1	y, Town or Loc	4 //	:11		. 8				10	od. Inside Cit	
	within 72 hours after death with the Maryland ane. Than "natural", or Items 23s or 28s-f show in Madical Examinat must be notified at	Funeral Director	10e. Street and Number	,	0 - 1			,,,,,	p Code	111			10g. C	itizen of Wh	nat Coun	try?	
	s 23s	erai	3304 Ken	1000	12. Was Deceden	Ever in II	S 13 W	Vac Dece	XIX'	ispanic Ori	ain? (Sne	city Ves or h	Jo.	14. Race	- Americ	an Indian	
	Iter de	nu	11. Marital Status 1 □ Never Married 2 □ □		Armed Forces	?				n, Mexicar	n, Puerto F	cify Yes or I Rican, etc.)	10-		White,		
336	urs af	by	3 Widowed 4 □ Divor		1 □ Yes 2 If Yes, Give Year or Dates:		1	☐ Yes	2 No	Specify:				Specify:	Bla	ick	
215-0036	ature ical E	Completed	15. Dece (Specify only hi	dent's Edu	cation		16a. Deced	ent's Usi	ual Occup	ation during mos	t of working	20	16b. l	Kind of Bus	iness/Ind	lustry	
215	thin 7	nple	Elementary/Secondary (0-1		College (1-4or	5+)	flife. D	O NOT	use retired		i oi workii	<i>'</i> 9	1	1. 6	10	a.	_
2	filed with Hygiene. Ither than	S	10th				Nur	Se.	5 7	tige				ear	m	Car	ی
ng	tal H d oth	To Be	17 Rather's Name (First, Mid	dle, Last)	Tobac	0.0				18. Wothe		(First, Midd	ia-Maide	n <i>Sumame,</i>)		
<u>\Z</u>	is 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if them 23s or 28s-f show them 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event. I'm Medical Examinational be notified at		ROVERC N	1.	Johns	011	401 14 11		- (0)	/ 1		FO	10		A- A- 72'-	0- 4-)	
Maryland			A formant's Name/	onship (PA. A	16-	19b. Mailing	g Adores	(Street	- 0	I IAI	Route Nun	1/1	The s	tate, Zip		1
	1 and Health em 27 ther tr	1	20a. Method of Disposition	OOT	1 puny	20b. P	lace of Dispos	sition (Na		CNO	, / V	ate_		Logation - C	ity or To	wn, State	
Baltimore	Pages nent of nt: If It iry or o		1 XBurial 2 ☐ Cremat		emoval from State	\mathcal{L}	emetery, on m	atory	ther plac	Θ)	2/20	dal	A	h.L	0	m	
Ħ	permit. Pages 1 and Department of Health Important: If Item 27 eny injury or other tr 8058.		4 Donation 5 Other		1	73	1 Du-1	TO IA	ucd Addre	Sol Fall	VERR	106	100	LICA	1/2	العارا	
Ba			Variation		LOCAL		87	100	Bilo	79	JOD	1 nd	Olich	wo	nic	याउ	3
			23a. Part1. Enter he disease shock, or heart failure.	, or compli	cations that cause	d the deat	h. Do not ente	er the mo	de of dyin	g such as	cardiac o	r respiratory	arrest,	w11, -		Approximate	9
	Physician /Medical Examiner		shock, or heart failure. Immediate Cause (Final	List only or	0			1	1	1.	a 11.11					Onset and D	
			disease or condition resulting in death)		Due to (or as a consequence of):												
					Chronic red foulur.												
		ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		b. Due to (or as a consequence of):												
<	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events	1													
o	be executed ician and burial-transit		resulting in death) Last		Due to (or a	s a conseq	uence of):										
<u></u>	ate be nysici he bu	icai			d												
89	death certifical e attending phy id for use as th	by Physician/Med	IF FEMALE:												!		
Вох	ath ce ttend	lan/	23b. Was decedent pregnant in the past 12 months?	2	3c. If yes, outcom 1 ☐ Live birth	2 Feta	ildeath 3□		oregnancy	,				23d. Date Mont		,	'ear
0.	the a	/sic	1 Yes 2 No		4□Pregnant a 9□Unknown	at time of d	eath 5□	Other (s	specity)							,	
P.O.	Attending Physician: The law requires that the de rdeath. sctor: Atter this certificate has been signed by the sy the funeral director, page 2 should be detached by the funeral director.	Ph)		ditions cor	atributing to death							23e. Die	23e. Did tobacco use contribute to the cause of death				eath?
Š			1 🗆 Yes								2 No 3 Probably 4 Unknown						
Ö		Completed															
3ec		ldш			24a. Was ar autops perior								prior to completion of cause of				
a			05.145									1 Tes	2 N	10 1	Yes	2 No	
Χ) Be	25. Was case referred to me examiner? 1 Yes 2 No	_	26. Place of Death (Check only one)												
ō		. To	27. Manner of Death				28b. Time of	301				28d. Describ				′)	
Division of Vital Records,		tion	1 ☑Natural 5 ☐ Pe	nding estigation	28a. Date of Injury (Month, Day Year) 28b. Time of lnjury M 28c. Injury at Work? 1 ☐ Yes 2 ☐ No												
N.	Attendii r death. ector: A by the fu	iffice	do	uld not be termined	289. Place of injury - At nome, farm, street, factory, office							t and Number or Rural Route Number,					
Ö	s afte	Certification:	4 Homicide building, etc. (Specify)								July Gr 1	Jenn, Old	,				
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical ((Check only 2 Med	ifying Phy ical Exami	sician: To the bes	of examina	owledge, death	occurre	d at the tir	ne, date ar pinion, dea	nd place, a with occurre	and due to the	e, date a	s) and man	ner as st	ated. the cause(s))
	the I the I	Medi	one)		and manner s	tated.			9c. Licens					ate signed			
	T Will	-	29b. Signature and title of ce		10			2			7	6	230. D				
	\cap											9		3 11:			
	10		30. Name and address of per	son who co Aw L			п 23a) (Турө, 1 Ска Цо		F-0	× 1	cine	STE	2	10	Bou	11 2.	0715
	Sta	**	31. Date filed (Month, Day, Y		2. Regis												
	Regist		MAR 1 7	2006	1200	. It	Some	6									

			1 - For Amend Item	State of Ma 29d per Di	ryland / D • ,G853,	epartment of L 03/16/06dhb Certificate of	lealth and M Death	lental Hygie	ene 0 0 6	08144			
	Physici /Medic		1. Aecedent's Name (First, Middle, CATHERINE		JUST	CE	2. Date of Death Month 03	Date of Death 3. Time of Death					
	Examin		42 Fecility Name (If not institution, g	Ken. Ga	rdens	CATONS	Location of Death	MD	BALTI	MORE			
I	Funeral Director		5. Social Security Number 577-01-6293 Usual Residence of Decedent	1011 100	99	Months Days	8. Date of Birth (Month, Day, Y June 12,	ea <i>r)</i> 9. Birth Cou	place (State or Foreign intry) cyland				
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, it a Medical Examinar must be neitling at 2008.	by Funeral Director	10a. State 10b. County 10c. City, Town or Location MD Baltimore Catonsville										
			10e. Street and Number 715 Maiden Choi	ce Lane CR		10f. Zip Code	21228	10g	. Citizen of What Cou USA	intry?			
			11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 M N If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Whi	, etc.			
		Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry										
		To Be Cor	12 17. Father's Name (First, Middle, La	2	s	upervisor	18. Mother's Name	e (First, Middle, Ma	payrol iden Sumame)				
Maryland			George Wesley Ament Annie Matilda Naylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
			Lynn Alim/nied	ce		53 Persimmon Disposition (Name of				Town State			
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☒ Donation 5 ☐ Other (Spe	ocity)	cemeter	y, crematory or other plac	ce)	Sate 20	c. Location - City or 1	OWII, State			
Bal			21. Sitrature of Funeral Projection Linear Ld S	// war	ector	State Anat Baltimore,	omy Board MD 2120	1					
	To the Hospital or Attending Physician: The law requires that the death certificate be exacuted by the fact. Within 24 hours after d-ath. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit and property.		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate cause (final disease or condition)										
8760,			resulting in dealin)										
		ilon; To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease 0: injury that initiated events resulting in death) Last	c	a consequence o								
			resulting in death, cast	d	a consequence o	ot):							
O. Box 6			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	,		23d. Date of delin	,			
Д			Part II. Other significant condition	s contributing to death b	ut not resulting in	the underlying cause giv	en in Part I.	23e. Did toba	l tobacco use contribute to the cause of death?] Yes 2⊠No 3 ☐ Probably 4 ☐Unknown				
al Records,								24a. Was an autopsy performs	prior to c	topsy findings available ompletion of cause of 2 No			
Vital			25. Was case referred to medical examiner? 1 Yes No	Hospital: 1 ☐ Inpatie	26. Place of Death /Che Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Physical Home 5					seck only one) 5 ☐ Residence 6 ☐ Other (Specify)			
on of			27. Manner of Death Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year) 28b. Time of 28c.			mer No.						
Division		Certification:	2 Accident Investigation 3 Suicide 6 Could not determine	ot be	rm, street, factory, office	28f. Location (Stre City or Town,	Location (Street and Number or Rural Route Number, City or Town, State)						
		edical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the best xaminer: On the basis of and manner sta	l examination and	, death occurred at the tir d/or investigation, in my o	πe, date and place, pinion, death occur	and due to the cau red at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)			
	To the within 2 To the complete	Me	29b. Signature and title of certifier	MD		29c. Licens			I. Date signed (Month				
•				tho completed cause of d	4.0 2	Type, Print)	Lusu:	(6, m	March 7, 2	2000			
**	Sta Registi		31. Date filed (Month, Day, Year)	39 Begistr	ar's Signature		11		J				

Deposition in the first Members of the Control of t					State of Ma	aryland /	Department o	f Health a	nd Mental Hy	giene	
Provided Common Services of the delicition per sound or market of the services of the delicition per sound or market of the services of the delicition per sound or market of the services of the delicition per sound or market of the services of the servic			•	for State Registrar			•			711116	08145
## Country As Seath Assembler of present removed Assembler of present of the property of t		Physicia	an	1. Decedent's Name (First, Middle	1000	7			Month	Day Yea	7720
Provided Toward Control of Contro	3.			4a. Facility Name (If not institution)	give street and number)		4b. City, Tow	n, or Location of			
Security Control Proceeding Security Control Proceding P	£.	Examin	er	D C - 1	top to o	RBA1-	imore	2		N	/p
Double Residence of General Top County Top C					6. Sex 7. Ag		Months Da	ear If Under 2	4 Hrs. 8. Date of Birt Min. (Month, Da	h 9. B	
Specific Market Dispersion						07	115.		11/19/	1918	NY
Specific Market Dispersion		how the			»/»	10c. City, Tox					
Specific Market Dispersion		the Ma	ecto		N/A					10g Citizen of What	
Specific Market Dispersion		3a or	I Dir		Road		101. 2.p 000			Tog. Chizon of What	-
Physician (Modela) Examinary To go go and a substituting in death) To go go and a substituting in death) To go go go and a substituting in death) To go go go and a substituting in death) To go go go go go go go go go go go go go		ems 2	Iner	11. Marital Status	Armed Forces?		13. Was Decedent If Yes, specify (of Hispanic Orig Cuban, Mexican,	in? (Specify Yes or No- Puerto Rican, etc.)	- 14. Race - Ar Black, W	
Physician (Modela) Examinary To go go and a substituting in death) To go go and a substituting in death) To go go go and a substituting in death) To go go go and a substituting in death) To go go go go go go go go go go go go go	36	rs afte	by Fi		If Yes, Give	N o	_				
Physician (Modela) Examinary To go go and a substituting in death) To go go and a substituting in death) To go go go and a substituting in death) To go go go and a substituting in death) To go go go go go go go go go go go go go	2-0	72 hou nature licel E	ted	15. Decedent	s Education	16	a. Decedent's Usual Oc (Give kind of work de	ccupation	of working	16b. Kind of Busines	ss/Industry
Physician (Modela) Examinary To go go and a substituting in death) To go go and a substituting in death) To go go go and a substituting in death) To go go go and a substituting in death) To go go go go go go go go go go go go go	121	within ne.	mple	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO NOT use re	tired)			
Physician (Modela) Examinary To go go and a substituting in death) To go go and a substituting in death) To go go go and a substituting in death) To go go go and a substituting in death) To go go go go go go go go go go go go go	d 2	filed v Hygie other t					Masse		's Name (First, Middle,		_h
Physician (Modela) Examinary To go go and a substituting in death) To go go and a substituting in death) To go go go and a substituting in death) To go go go and a substituting in death) To go go go go go go go go go go go go go	an	fental rked o	O Be	Richard F. Ju	oitz				Margaret	Ebering	
Physician (Modela) Examinary To go go and a substituting in death) To go go and a substituting in death) To go go go and a substituting in death) To go go go and a substituting in death) To go go go go go go go go go go go go go	Mary	d 2 shouth and N									, Zip Code)
Physician (Modela) Examinary To go go and a substituting in death) To go go and a substituting in death) To go go go and a substituting in death) To go go go and a substituting in death) To go go go go go go go go go go go go go		ss 1 an of Heal item 2			2 C 2	20b. Place	of Disposition (Name o	1	Date	20c Location - City	or Town, State
Physician (Modela) Examinary To go go and a substituting in death) To go go and a substituting in death) To go go go and a substituting in death) To go go go and a substituting in death) To go go go go go go go go go go go go go	Ë	Page tment tant: If jury or		4 □ Donation 5 □ Other (Sp	pecify)	Meado				06 Baltimo	ore MD
Physician (Medical Examiner Physician (Medical Examiner Physician (Medical Examiner) P	Ball	Departiment Departiment Important once.		21. Signature of Funeral Service L	ctor P. Dod	la,Jr.	Charles	dress of Facility L. Steve Fort Ave	ens Funeral	Home, Inc	Šô.
Physician (Modifical Examiner of Modern Day 1997) The state of the st				23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each li	d the death. Do	not enter the mode of	dying, such as o	cardiac or respiratory ar	rest,	Approximate Interval Between
Sequentially ist conditions, any, leading to immediate cause, first Underlying and the cause of				disease or condition	a. Ketra	tetor	, Sept	10 >	10ch		18 hours
Part Company					Let to for as	a consequence	DUOMI	A			4dnys
Part Company		D II	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence	of:				7
See See		al-tran	xam	that initiated events resulting in death) Last	c. Due to (or as	a consequence	e of):				
1 Yes 2 No 1 Yes N	1760	ysicier	icai		L d						
1 Yes 2 No 1 Yes N	89 x	entifica ling ph e as th	Med	IF FEMALE:		7.					
1 Yes 2 No 1 Yes N		attenc	cian/	in the past 12 months?	1 Live birth	2 Fetal deal					,
1 Yes 2 No 1 Yes N	Ö.	it the d by the tached	hysi	9 Unknown				,			
1 Yes 2 No 1 Yes N		res the signed I be de	by P	Part II. Other significant condition	ns contributing to death b	out not resulting	in the underlying cause	given in Part I.			. /
1 Yes 2 No 1 Yes N	Sor	v requi	ieted	A DO D	PARI F	SAL	100	`/			
25. Was car referred o merical sexaminer? 26. Place of Death (Check only one) 27. Manner of Death 28. Describe how injury occurred 28. Place of Death (Check only one) 28. Date of Injury at Work? 28. Date of Injury	Re	The lar	dmo	Paracate	PA FA	11:30	0		autop perfo	osy prior t ormed? death	o completion of cause of
27. Manner of Death 1 1 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	ital	entifice ctor, p	0	25. Was cal referred o me ical	7	11019					
30. Name and address of person who is poleted cause of death (Item 23a) (Type, Print) H_Near Reproducts Bon Second 12000 West Battimore Street State 31. Date filled (Month, Day, Year) 32. Registrar's Signature	of \	Physic this co	ို	1 ☐ Yes 2 ☐ No	1 Z Darratio			4 1401			ресіfу)
30. Name and address of person who is poleted cause of death (Item 23a) (Type, Print) H_Near Reproducts Bon Second 12000 West Battimore Street State 31. Date filled (Month, Day, Year) 32. Registrar's Signature	o	th. : After s funer	tion	1 ☑ Natural 5 ☐ Pending	(Month, Da	y Year)				low injury occurred	
30. Name and address of person who is poleted cause of death (Item 23a) (Type, Print) H_Near Reproducts Bon Second 12000 West Battimore Street State 31. Date filled (Month, Day, Year) 32. Registrar's Signature	Jivis	or Atter after dea Director in by the	ertifica	3 ☐ Suicide 6 ☐ Could r	ned 286. Flace of In		farm, street, factory, of	ice			Rural Route Number,
30. Name and address of person who is poleted cause of death (Item 23a) (Type, Print) H_Near Reproducts Bon Second 12000 West Battimore Street State 31. Date filled (Month, Day, Year) 32. Registrar's Signature	_	ospitel hours unerel ly filled		29a. Certifier 1 Certifyin	g Physician: To the best	of my knowled	ge, death occurred at th	ne time, date and	i place, and due to the	cause(s) and manner	as stated.
30. Name and address of person who is poleted cause of death (Item 23a) (Type, Print) H_Near Reproducts Bon Second 12000 West Battimore Street State 31. Date filled (Month, Day, Year) 32. Registrar's Signature		the H thin 24 the F mplete	Medi	one)	and manner st	ated.					
H_Neal Reynolds Bon Secous Hospital 2000 West Battimorp Street State 31. Date filed (Month, Day, Year) 32 Aegistrar's Signature		7.≊ 7 ⊗		N. Moult	Ou non Dal)	a MY	1	2716	3	02-11	4-2006
State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	-	10		30. Name and address of person	who completed cause of o	death (Item 23a) (Type, Print)	110	202 1.	D-11	
		Ψ		11 Date filed (Month Col. Vocal	DKS DON	rar's Signaffun	15,170spi	tal, 20	CO Was	T DATTM	orp Street
	1			MAR 1 7	107 .		har war	,			

			For		State of Mar			t of Healt e of Dea		lental H		000		181	1,6
			Registrar 1. Decedent's Name (F	irst Middle Last		- 06	Tillicati	e oi Dea	2111	2. Date of D	Reg. No	.000	3.	3. Time	of Death
18	Physici	an	DEMERI				OHNS	son		Month MARCI	Da		ar C	4:4	
	/Medic	100	4a. Facility Name (If not		street and number)			Town, or Local	tion of Death	141/11/01	·	County of E		1 1	
	Examin	er	THE JOH	1.1		SPITAL	-	LTIMO		CITY					
	Funeral Director		5. Social Security Number 139-81	per 6. Sea		n yrs. last birthday Yrs.) If Under Months	1 Year If U	nder 24 Hrs. urs Min.	8. Date of B	irth Day, Year)	4 Å	Birthpt	ace (State	e or Foreign
	pu *		Usual Residence of De- 10a. State 10	b. County	1	0c. City, Town or L	ocation						10	or Inside	City Limits
	e Maryland Ba-f show	ctor	MD			Balt	imo	re						1 X Y	es 2 No
	's after death with the Marylan', or Iteme 23a or 28a-f show	Funeral Director	10e. Street and Numbe 3106 Gr	indo	n Aver	sue	10f. Zip	1214	+		(ISA	1		
	er de	nue	11. Marital Status		12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Deced	dent of Hispani cify Cuban, Me	ic Origin? (Spo xican, Puerto	ecify Yes or N Rican, etc.)	10-	14. Race - / Black, V			
36	hours after ural; or Ite	by F	1 ☐ Never Married Widowed 4 ☐		1 Yes 2 No If Yes, Give Year or Dates:		1 🗆 Yes	2 No Spe	ecify:			Specify:	3/0	ck	
5-0036	72 hours natural',	edi	15.	Decedent's Edu	cation	16a. Dece	edent's Usua	al Occupation			16b. K	ind of Busin	es s/Ind	ustry	
215	nin 72 in "na Medic	piet	(Specify of Elementary/Seconds	onfy highest grad	e completed) College (1-4or 5+)	(Give	b kind of wor DO NOT us	rk done during se retired)	most of work	ing	11	001	11		
212	illed withir Hygiene other then	Completed	124	3 (0-12)	00110g0 (1 401 04)	Nu	4se	A11	se		[7]	ear	W		Ne
nd	al Hy al Hy d oth	Be (17. Father's Name (Firs	st, Middle, Last)				18. N	Mother's Name	First, Middle	e, Maiden	Sumame)			
yla	thould be id Menta marked matic ev	2	8/105	Phi	lips				ass	ies	300	He			
Maryland	2 a m m	0.11	19a. Informant's Name	/Relationship (Ty	rpe, Print) (50	19b. Mail	ing Address	(Street and N	umber or Run	al Route Num	ber, City o	or Town, Sta	te, Zip (Code)	1
	s 1 and f Health Item 27 other to		Erast	مل کیا	hason -	20b. Place of Disp	66	rinde	A MC	ue, I	34	10 M	D	عاد	414
Baltimore	ges 1 If Ite or ot		20a. Method of Disposit		temoval from State	cometery, cre			1 0/		200. L	ocation - City	OF TOV	vn, State	
ij	Pa men ant: ury		4 Donation 5	_		Arbuti	us (e	Meter	13/1	6/06	150	410.	M	ν.	
Bal	Departition of Import		21. Signature of Funera	al Service Licens	**)		Vaug	Addressor	Creen	ie tu	yu e	ral-	Sei	oi c	ces
			23a. Part1. Enter the d	lisease or compl	ications that caused th	e death. Do not er	ter the mod	e of dying, such	th as cardiac	r respiratory	Dat:	10.M	D	Approxin	nate
			shock, or heart fa Immediate Cause (Final	ilure. List only or	ne cause on each line.				,	o. roopiratory	411001,			Interval E Onset ar	Between nd Death
	Physician / /Medical		disease or condition resulting in death)	a1		LDIAL 11	VFAR	CTICH	7					7 D	AYS
100	Examiner			- 1	CONT. OF CONTRACT PROPERTY.	consequence of):	-01	DISE	ASE				,	n W	Ch65
		ē	Sequentially list conditi if any, leading to imme	ions, diate	Due to (or as a	consequence of):	CET	Diac	A 3C					0	C-TIPE J
V	ecuted and -transit	min	cause. Enter Underlyir Cause (Disease or inju- that initiated events	ng ry	HYPERI	IPIDEMI	A						11.	2 YE	EARS
Ć	× =	Examine	resulting in death) Last	· •		consequence of):								-	
19/	ste be ex nysician ne buria	icai			DIABET	ES MEL	LITU	S					13	5 YE	EARS
68	tificat ng phy as th	e													
Box	requires that the death certifica een signed by the attending pr nould be detached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pre	egriani	3c. If yes, outcome of 1 Live birth 2		□Ectopic pr	regnancy				23d. Date of		,	V
_	the att	sici	in the past 12 moi	nths?	4☐Pregnant at tin		Other (sp		·			Month		Day	Year
P.O.	at the de	Phy	9 Unknown												4 > 110
	res that signed b	þ	Part II. Other significal	nt conditions co	ntributing to death but i	not resulting in the	underlying c	ause given in F	Part I.		Yes 2	use contribu	/		⊡Unknown
orc	w require been si should I	ted								1	165 2				
ec	8 8 6	Completed									opsy	24b. Wer prior deal	to com	sy findin	gs available if cause of
= =	Th ate pag									1 Tyes	formed? 2 XNo	10		2XN0	
Vit	Physician: r this certificant all director,	Be	25. Was case referred examiner?	-	lospital:				Ptace of Deat						
o	Phys this ral di	. To	1 ☐ Yes 2 No 27. Manner of Death		Inpatient	2 ER/Outpatie		PRc Injury at	Nursing Ho	me 5 Re 28d. Describe			Specify,)	
on	ding I h. After funer	tion		Pending investigation	28a. Date of Injury (Month, Day Y	'ear) Injury	М	28c. Injury at Work? 1 ☐ Yes	1		,-	,			
Division of Vital Records,	Attending in death.	fica	3 Suicide 6	Could not be	28e. Place of Injury	- At home, farm, s	treet, factory	y, office		28f. Location			r Rurai	Route N	u <i>mb</i> er,
D	ellor/ s efter il Dire	Certification:	4 Homicide		building, etc.	Specify)	,			City or T	own, State	9)			
	To the Hospitel or Attent within 24 hours effer death To the Funerel Director: completely filled in by the	Medical C	29a. Certifier 1 (Check only 2 one)	≰Certifying Phy	sician: To the best of oner: On the basis of earth and manner state	kamination and/or is	th occurred nvestigation	at the time, da , in my opinion	ate and place, n, death occur	and due to th	e cause(s e, date an) and manne d place, and	r as sta due to	ated. the caus	Θ(S)
	within To th Comp	Me	29b. Signature and titte	of certifier	0.1		290	c. License num	nber			ite signed (A			
	,		Fra	am. K	oll MD	PITO		RES.	-000		MA	RCH	11	20	006
	1		30. Name and address		ompleted cause of dea	th (Item 23a) (Type								212	87
	2		TODD KOLB,	P.A			,600 N	JORTH W	JOLFE	STREET	, BA	LTIMO	RE,	MAR	YLAND
10	Sta Registr	- 7	31. Date filed (Month, I		32. Rigistrar	Signature	South								

			1 - For State Registrar	State o	f Marylar			of Health of Deat		lental Hy	gien	ZIIIIh	0811	+ 7
			1. Decedent's Name (First, Middle,	Last)						2. Date of De Month	eath Da	ay Year	3. Time of De	ath
	Physicia /Medic		John	J		Jaskot				March	9, 2	006	1356	М
5	Examin		4a. Facility Name (If not institution,	give street and nu	m <i>ber)</i>		4b. City, To	wn, or Location	on of Death		40	c. County of Death	1	
			Montgomery Gener	al Hospi	tal_		01ne	•				Montgome	ry	
	Funeral			6. Sex 1 1 M 2 □ F	7. Age (In yrs.		If Under 1 Months	Year If Unc Days Hour	der 24 Hrs.	8. Date of Bi (Month, D Dec. 5,	rth a <i>y, Year</i>	9. Birth	place (State or F	_
	Director		168-18-4373	18 M 20 F	84	Yrs.				Dec.5,	192	21 Penn	sýlvania	1
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation						10d. Inside City I	Limits
	aho	ō	Maryland Montgom	nerv		lver S							1 🗀 Yes 2	∑ No
	the N	Director	10e. Street and Number				10f. Zip C	ode		-	10a C	itizen of What Cor	intry?	
	with a or	ă	15101 Interlact	han Drive	Ant C	20	209				_	ted State	•	
	death with the Maryland ma 23s or 28s-f show	Funerai	11. Marital Status		edent Ever in U				Origin? (Sp	ecify Yes or N		14. Race - Amer		
	ter d	Fu	1 ☐ Never Married 2 ☐ Marrie	Armed Fo		2			can, Puèrto	ecify Yes or No Rican, etc.)		Black, White	, etc.	
3	al', o	þ	3 X Widowed 4 ☐ Divorced	If Yes, Gi	ve 192 Pates:	+6	1⊡Yes 2§	No Spec	eity:			Specify: W	hite	
3-003e	2 hor	Completed	15. Decedent	s Education		16a. Dece	dent's Usual	Occupation done during m	nost of word	vina		Kind of Business/I		
7	hin 7	pie	(Specify only highest Elementary/Secondary (0-12)		1-4or 5+)	life.	DO NOT use	retired)	TOST OF WORK	ung.	Uni	ited Serv surance (vices Li Company	te
V	gient gien er th	Con		College (Att	orney							
2	al Hy al Hy d oth	Be (17. Father's Name (First, Middle, L George		skot					e (First, Middle		n Sumame)		
yland	Ment Ment arked	ဥ	George	W. Ja	SKUL				Anna		zma			
Mar	2 sho and ie mu	i 13	19a. Informant's Name/Relationsh									or Town, State, Z		
e, ≤	and ealth m 27 ner tr		Philip R. Jaskot	:/ Son	200							ta, PA		
	of H of H if ite		20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation	3 □Removal from		Place of Dispo	matory or oth	er place)	Mar			Location - City or $tehall$,		
Ē	Pag ment ant: ury c	١.,	* 4 □ Donation 5 □ Other (Sp		Arı	_		ialPar	r/v			_		
Baitimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiens. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, its Medical Examinar must be notified at once.		21. Signature of Funeral Service L	icensee MOO	092	B B	2. Name and ethesd ethesd	Address of Fa a-Chevy a, Mary	icility Rob y Chas y1and	ert A. se, Inc 20814-	Pum 75 3501	phrey Fu: 57 Wisco	neral Ho nsin Ave	me enue
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that	caused the dea	th. Do not en	ter the mode	of dying, such	as cardiac	or respiratory	arrest,		Approximate Interval Betwe	
	Physician		Immediate Cause (Final disease or condition	D	MOLLA	OMEN	ı.						Onset and De	ath
	/Medical		resulting in death)	a. Due to	(or as a consec	quence of):	1							
	Examiner		On a second the line and distance	h										
. 10		ner	Sequentially list conditions, it ary, leading to immediate cause. Enter Underlying	Due to	(or as a cons	uence of:								
	ate be executed hysician and he burial-transit	Examin	that initiated events	с.										
Ď,	e exe ian a urial-i		resulting in death) Last	Due to	(or as a consec	quence of):								
3/60,	ate br nysic he bu	Ical		d										
õ	leath certificat attending phy I for use as th	Physician/Med	IF FEMALE:								I			
X O D	ith ce itendi	an/l	23b. Was decedent pregnant in the past 12 months?	1 Live	tcome of pregn birth 2 - Fet	al death 3	⊒Ectopic preç				ŀ	23d. Date of deli Month	very Day Yea	ar
	e death he atten hed for u	Sici	1 ☐ Yes 2 ☐ No	4□ Preg 9□ Unkr	nant at time of	death 5[Other (spec	cify)				77101111	<i>D</i> 2,	
r Ö	at the de d by the a etached	Phy	9 Unknown							220 Did	tobooo	use contribute to	the equipped of dea	ath?
Ś	w requires that s been signed b should be deta	Ď	Part II. Other significant conditio	LISA P	eath but not re	sulling in the t	inderlying cat	ase given in re	art I.			2 □ No 3 □ Pr	10	
2	een s	ted	Revert 1 ans	1001	7 '					-	103	20140 0011	John Toler	
Hecord	> 4 70	Completed	Lew Drona 1	Voscul	on Di	seas	2			24a. Wa aut	op sy	prior to c	topsy findings av completion of cau	ailable ise of
Y		Con	Polytothem	ia Vev	0					1 ☐ Yes	omed?	death? lo 1 ☐ Yes	28 No	
Vital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?					-	lace of Dea	th (Check only	one)			
0	S 50	၉	1 □ Yes 2 🗷 o			ER/Outpatie			Nursing H			6 □Other (Spec	cify)	
	ng Te	on:	27. Manner of Death Natural 5 Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time of Injury		c. Injury at Work?	· ·	28d. Describe	how in	ury occurred		
Division	eath.	Certification:	2 Accident investig	ot be			М	1 Yes 2	2 LI No		10:	111 5	. (6	
Ž	or At ther d lirect n by	E	4 Homicide determi	ned 286. Plac	e of Injury - At I ling, etc. <i>(Spec</i>	nome, farm, st <i>ify)</i>	reet, factory,	office		City or To		and Number or Ru ite)	irai Houte Numbe	r,
_	urs a		One Contilling	- Physician -		and decided	46	Ab- (*				(a) and =======	stated	
	To the Hospitat or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier Certifyin (Check only 2 Medical I	g Physician: To th Examiner: On the I	e best of my kn pasis of examin nner stated.	owiedge, dea ation and/or in	tn occurred at nvestigation, i	t the time, date in my opinion,	e and place death occu	, and due to the rred at the time	e cause , date a	s) and manner as nd place, and due	to the cause(s)	
	thin 2 the mple	Med	29b. Signature and title of certifier	and mai	mier stateu.		290	License numb	oer		29d. D	ate signed (Monti	h, Day, Year)	
	7 × 00			1 /	114		+	NEVA (>:11	OI	-5	lala	<u></u>	
	ألار		Immure		> WI)	Onin 1	1006	516			1710	6	
	257		30. Name and ddress of person Matthew C. McA					ilin D	ri ()1nov-	M = ===	lond 20	022	
	0		31. Date filed (Month, Day, Year)		• D • 181 Registrar's Sign		nce Pn	тттЬ р	ттле (лтиеу,	mary	rand 20	832	
	Sta Regist		MAR 1	7 2008	A second	the state of	South	P				Marine .		

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Mont 10-06 Day Physician Maryrose Kreis 11:35A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death Examiner Millersville Anne Arundel 8381 Sycamore Rd If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**X**CXF 212-22-8847 79 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location
Millersville 10d. Inside City Limits 10a State 10h Count in then "natural", or itame 23a or 28a-f ehow the Medical Examinar must be notified at MD Anne Arundel 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21108 USA 8381 Sycamore Rd Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 215 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Be Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Westinghouse ... Pages 1 and 2 should be filed w itment of Health and Mental Hygie tant: if Item 27 is marked other ti jury or other traumatic event, In Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julia C. Bien Huebert A Clagett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy J. Kreis Daughter In Law 8381 Sycamore Rd, Millersville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) permit. Page Department of Important: if any injury or 2005e. New Cathedral Cem 3-14-06 Baltimore, MD Funeral Service Licensee 21. Signatu 22. Name and Address of Facility Fink Funeral Home, P.A. Burnie, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 10 **Physician** -ailure /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregrant in the past 12 mg/lths? 3 Ectopic pregnancy ö Month Year 4☐Pregnant at time of death signed by the at d be detached fo 5 Other (specify) 1 ☐ Yes 2 ☑ No o 9☐ Unknown 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 2 No 1 ☐ Yes 1 No 1 TYes Division of Vital Attending Physician: director, To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3010 1 ☐ Yes this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No м investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Centifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 2 Medical 29b. Signature and title of certifig 29d. Date signed (Month, Day, Year) 29c. License number h Kidac 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician Year March 12, 2006 2:00 P M Mignon Pauli Kellermann /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8100 Connecticut Avenue Apt 610 Chevy Chase Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) Il Under 1 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Hours Months Days 1 □ M 2 🛛 F Director 577-36-7631 February 19, 1907 New York Usual Residence of Decedent 10b. Count 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Chevy Chase Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 238 Completed by Funeral 8100 Connecticut Avenue Apt 610 20815 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If Item 27 Ie marked other than "natural", or Itame 23 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 ♥ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Albert Pauli Marion Lunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 119 East 83rd Street #4A New York, New York 10028 Susan Kellermann/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ò 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State March permit. Page Department o important: if any injury or once. 4 □Donation 5 □Other (Specify) 17, Rock Creek cemetery 2006 Washington, D.C. 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Fuperal Service Licensee M00335 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Arrest Hour /Medical Due to (or as a consequence of): Examiner 2 Days Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transit or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Box 68760. Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕅 No Month 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown : After this certificate has been signed funeral director, page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Age 99 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was ... autopsy performed? Yes 2K No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Naturai 5 Pending investigation s after dec. Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0058401 March 13, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Erica Hwang, M.D. 8120 Woodmont Avenue #320 Bethesda, Maryland 20814 32 Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

			For State Registrar	State of	Marylar		artmen <i>rtificat</i>			ınd Me	ental Hyg	jiene 10g. No.	6 0	8150
	Physici	an	1. Decedent's Name (First, Middle, Las	,	7.100						2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	SHIRLEY L								MANCH			12:00 PM
	Examin	er	4a. Facility Name (If not institution, give Chapel Hill Nursi	ng Cent	ber) er			Town, or alls	Location of	f Death			unty of Death altimo:	re
	Funeral		Social Security Number 6. S	x 7	. Age (In yrs.	last birthday)	If Under	r 1 Year	If Under 2		3. Date of Birth		9. Birthi	place (State or Foreign
	Director		213-26-6663	☐M 2∏F	76	Yrs.	Months	Days	Hours	Min.	(Month, Day Sept 13) Md	ntry)
	pur		Usual Residence of Decedent 10a. State 10b. County		10c Ci	ty, Town or Lo	ncation							10d. Inside City Limits
	Marylis f sho	5	Md Balta	more	1	anda11		1						1 ☐ Yes 2 ☑ No
	28a-	Director	10e. Street and Number				10f. Zip				1	10g. Citizer	of What Cou	
	h with		4511 Robosson Ro	oad			211	.33				US	SA	
	deat	Funerai	11, Marital Status	12. Was Deced			Was Dece	dent of Hi	ispanic Orig	gin? (Speci	ify Yes or No-	14.	Race - Ameri Black, White,	
36	72 hours after death with the Maryland natural', or items 23e or 28e-f show Jical Executes coeffied at	by Fu	1 Never Married 2 Married	1 ☐ Yes :	2√∑ No	-	1 ☐ Yes		Specify:	,	, , , , ,	Sp	ecify: whi	
ö	hours tural	q pa	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Da	tes:	16a. Dece	dent's Heu	al Occup	ation				of Business/In	
15	in 72 n "na	piet	(Specify only highest grad	de completed)	Acc E . \	(Give	kind of wo	rk done d se retired	during most ()	of working	7	TOD. KING	or businessym	odstry
212	e filed within all Hygiene. cother than "	Completed	Elementary/Secondary (0-12)	College (1-	401 5+)	boo	kkeer	er				c1e	rical	
БП		Be	17. Father's Name (First, Middle, Last) UNKNOWN								First, Middle,		mame)	
yla	should be nd Mental marked	၉									Fowb1e			
Maryland 21215-0036	es 1 and 2 should b of Health and Menti fitem 27 is marked r other traumatice		19a. Informant's Name/Relationship (7 John Hundertmark	урө, Print) (friend							Route Number Le, Md	r, City or To 2178		Code)
	l and Healt tem 2		20a, Method of Disposition	(20b. I	Place of Dispo	sition (Na	ne of		Da			ion - City or To	own, State
OL	ages ant of tt: If it y or o		1 X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		tate Lak	cemetery, cre ce View	matory or o	other place orial	e) 3	-17-0			ille,	
Baltimore,	permit. Pages to Department of Himportant: If ite any injury or ot once.		21 Signature of Funeral Service Licen	SBB					. 1.		nt Fune	•	,	
Ö	P P P P P		Daige Haught	Herber	*	P	.O. E	ox 1	95 Sy	kesvi	11e, M	d 217	84	onaper
П			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that ca	used the deal	th. Do not ent	ter the mod	de of dyin	g, such as o	cardiac or	respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a		EF	181	+ 1	SET	TIA				Onset and Death
	/Medical Examiner		resulting in death)	Due to (d	or as a consec			, ,						
		e	Sequentially list conditions, if any, leading to immediate	b. Due to (c	or as a consec	quence of):								
J	uted d ansit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
o,	exec an an rial-tra	Exa	resulting in death) Last	Due to (d	or as a consec	quence of):								,
8760,	cate be executed physician and the burial-transit	dicai	(d										
9	entifica ling pl	Med	IF FEMALE:	00- 1/									1	
Вох	eath certifi attending p	ian	in the past 12 months?		ome or pregn th 2 ⊟ Feta Intattime of o	aldeath 3	⊒Ectopic p ⊒ Other (sa					23d	. Date of delive Month	ery Day Year
O.	by the a	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unkno		Jean 3	_ Other (s)) 6 Cily)						
<u>α</u>	B B	by Pt	Part II. Other significant conditions co	entributing to de	ath but not res	sulting in the u	nderlying o	cause give	en in Part I.		23e. Did to	bacco use	contribute to t	he cause of death?
Division of Vital Records,	w requires been sign should be										1 🗆 Y	es 2□N	lo 3□Prol	pably 4 🖼 nknown
eco	law re as be	Completed									24a. Was a			ppsy findings available impletion of cause of
Œ.		Com									perfor	med?	death? 1 ☐ Yes	
/ita	Physician: 1 this cartificer al director, p	Be	25. Was case referred to medical examiner?	Uessitel.			- , ,	0"			Check only or			
of \	shys this al dir	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 □ In 28a. Date o		ER/Outpatier			4 🗀 1901		e 5 🗆 Resid	•		5 y)
o	ding After funer	tion	1 ☑Natural 5 ☐ Pending	(Month	, Day Year)	Injury	м .	28c. Injun Worl	k? Yes 2 □ N		od. Describe III	OW Injury O	Scurred	
/isi	or Attending after death. Director: Afte in by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	286. Place		ome, farm, sti					f. Location (S	treet and N	umber or Rura	al Route Number,
Ö	s after	Certification:	4 Homicide	buildin	g, etc. (Speci	ly)					City or Tow	n, State)		
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical (29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Medical Exam	/sician: To the l	best of my kno	owledge, deat	h occurred	at the tin	ne, date and	d place, an	id due to the o	ause(s) and	d manner as s	tated.
	the hin 24 the F	Medi	one)	and mann	er stated.				e number					
1	7 vi i	<	29b. Signature and title of certifier	1.0			1		i 3 4	62			igned (Month,	2006
	0				of death (It-	m 23a\ /T		-						
	0		30. Name and address of person who co	ar no	共10	8 0 A	END !	7.J.	1700	7 20	10 7	1113	3	
	Sta	ate	31. Date filed (Month, Day, Year)		gistrar's Sign	ature								
	Registi	rar	228 D 1 D 0	noc 2		M A	agget !							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 ELIZABETH BLATTNER March 13. LODEN 12:06 A^M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 11 Over Ridge Court Baltimore Baltimore County If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 □ M 2 🔀 F 85 498-09-2796 Feb 1, 1921 Missouri Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland | Baltimore County Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 11 Over Ridge Court, #2421 21210 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes. 2 No If Yes. Give Year or Dates: 144-146 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Medical Medical 4 yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) August Edward Blattner Elizabeth Katherine Middlekamp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Loden Barbuti (Dau hter) 39 Tenby Court, Timonium, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 3/14/2006 Baltimore, Maryland 21. Signature of Functor Service Mitchell-Wiedefeld Funeral Home, Inc. Martin D. Lawson 6500 York Road, Raltimore, Maryland 21212 Approximates the mode of dying, such as cardiac or respiratory ariest. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) BOPOROSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last RHEYMATICA Due to (or as a consequence of IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnapt 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacoo use contribute to the cause of death? 1 Ses 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 1 ☐ Yes 2 **N**o 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month Day, Year) a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pallan, M.D., 1205 York Road, Suite 30, Lutherville, Maryland 21093 31. Date filed (Month, Pay, Year) MAR 1 7 2006 32. Registrar's Signature

12

Registrar

Director:

within 24 hours e To the Funeret C

Physician

/Medical

Examiner

Director

Funerai

à

Completed

Be

Funeral

Director

7 is marked other then "natural", or Iteme 23a or 28a-f ehow traumatic event, the Modical Examiriar must be notified at

al Hygiene.

permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Importent: If Item 27 is marked oth eny injury or other traumatic event <u>once.</u>

Physician /Medical

Examiner

and

signed by the attending physiclen be detached for use as the buria

Physician/Medical

Completed by

Be

မ

Certification:

Medical

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

				State of Maryland / Department of Health and No. 1 - State Registrar Certificate of Death	Mental Hygier	2000	8:52
	13.		ð.	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
		Physici /Medio Examir	cal	John Bernard LaRosa, Sr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	March 12,		22:15 ^M
				Upper Chesapeake Medical Center Bel Air		Harford	
		Funeral Director		5. Social Security Number 212-38-1687 Usual Residence of Decedent	8. Date of Birth (Month, Day, Yea Sept. 17,		ace (State or Foreign y) yland
		land ow		10a. State 10b. County 10c. City, Town or Location		10	d. Inside City Limits
		death with the Maryland ms 23a or 28a-f show rmust be notified at	Director	Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code	10g. (Citizen of What Count	1 ☐ Yes 2 ☐ No
		3a or	0	3 Waterview Way 21040		USA	•
		death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - America Black, White, e	
	5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, its Mudical Experiment be natified at 2008.	by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		Specific	ite
		72 h	etec	15. Decedent's Education (Specify only highest grade completed) (Sive kind of work done during most of work file. DO NOT use retired)	king 16b.	. Kind of Business/Indu	ustry
2	2121	filed within Hygiene.	Completed	Elementary/Secondary (0·12) College (1-4or 5+) 12 Construction Inspector		ounty Gove:	rnment
त		filed Hygi other			ne (First, Middle, Maid		
3	<u>lan</u>	Aental Aental rked o	To Be	Ernest Bernard LaRosa, Sr. Sallie	El:	izabeth M	kVicker
	Maryland	2 should and Men is marke	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rus	ral Route Number, Cit	y or Town, State, Zip (Code)
	2	and seatth m 27		Cynthia Kennedy-LaRosa - Wife 3 Waterview Way, Edjew			- 0
3	or a	it of H it of H if ite or otl		1 Burial 2 Cremation 3 Removal from State	CONTRACTOR OF THE PARTY OF THE	Location - City or Tow	n, State
3/12/06	를	it. Pa				son, Maryl	
<u> </u>	Ba	permit. Departrimports any inju		1317 Cokesbury Roa	McComas Fu		
40		装 一		23a. a.11. Enter the hour a, or complications that caused the death. Do not enter the mode of dying, such as cardiac			Approximate Interval Between
	A	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. My 2 Cay thut Infavction Due to (or as a consequence of):			Onset and Death
		Examiner		Sequentially list conditions, b.			
\	4	bet	nlne	Sequentially list conditions, it any, reading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events c.			
7	,092	be executed sicien and burial-transit	Ical Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):			
100	687	<u> </u>		d		1	
38C	D. Box	atter for u	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of deliver Month	y Day Year
\circ	Ρ.	es that the de igned by the be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	cause of death?
特	ds,	sign d be	d by		1 🗀 Yes	2 No 3 Proba	bly 4 Unknown
5	ecords	w require should	ompleted		24a. Was an		sy findings available
7	Re	The far te has age 2	Шо		autopsy performed	? death?	pletion of cause of
17	ta	sician: The lay certificate has re tor, page 2	Bec	25. Was case referred to medical 26. Place of Dea examiner?	th (Check only one)		**
1	of V	Physician: this certific ral director,	To	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 NOOA Other: 4 ☐ Nursing H	ome 5 Residence)
EG		Attending Physic results of the function of th	atlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 No	28d. Describe how in	njury occurred	
B	Division	s after de el Directo ed in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St	t and Number or Rural tate)	Route Number,
آ		To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical (29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and manner stated.	, and due to the cause rred at the time, date :	e(s) and manner as sta and place, and due to	ited. the cause(s)
		To ti withi To ti	Ž	29b. Signature and title of certifier 29c. License number		Date signed (Month, D	
		λ		Mount (hamas ms) DOOZG3L8		2/13/06	
		4		Microsoft Mills 1 ms DOOZC3LV 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Republic Thomas (4) 3.445 E 1314 Hill Corporate C	L. No A	Hoi wall -	ud Dinne
	96	St	ate	31. Date filed (Month, Day, Year) MAR 7 7006 32/Registrar's Signature	iv y	in regulary is	un zwy

		1	For State Registrer	State of Marylan		rtment of H			ene 2006	08153	
	Physici	an	Decedent's Name (First, Middle, Last) William	Henr	У	McCro	rey	2. Date of Death Month	Day Year	3. Time of Death 6:25p M	
1	/Medio Examin	200	4a. Facility Name (If not institution, give s 1681 Cliftview A			4b. City, Town, or Balt:			4c. County of Death		
	Funeral Director		210 00 30 10	7. Age (In yrs. 1		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 10–4–5	9. Birth <i>Co.</i>	place (State or Foreign intry) Md .	
	Maryland f show		Usual Residence of Decedent 10a. State 10b. County Md . NA		y, Town or Lo					10d. Inside City Limits Yang Yes 2 □ No	
	with the 1 3a or 28a-	Il Director	10e. Street and Number 1681 Cliftview Av	enue		10f. Zip Code 2121.	3	10	Og. Citizen of Whal Cou USA	intry?	
980	be filed within 72 hours after death with the Maryland ital Hygiene. dother than "natural", or itema 23a or 28a-f show event, the Medical Exerting rount be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	1	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: B		
Baltimore, Maryland 21215-0036	e filed within 72 ho Il Hygiene. other then "netur vent, the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12th grade	cation e completed) College (1-4or 5+)	(Give life. L	dent's Usual Occup kind of work done DO NOT use retired nter	during most of work	ing 1	School of Business/I School of University		
land		To Be C	17. Father's Name (First, Middle, Last) Walter	McCr	orey		18. Mother's Name	e (First, Middle, N	faiden Sumame) Rice		
Mary	is 1 and 2 should of Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty) Eunice McCrorey	_{De, Print)} Wife		•	and Number or Rura view Ave.		City or Town, State, Z	ip Code) 21213	
more,	Pages 1 and of Heint: If item		20a. Method of Disposition 1√2 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)		emetery, crer	sition (Name of natory or other place) m. Park	ce)	Date 2 B-06	20c. Location - City or 1 Randallsto		
Balti	permit. Pages Department of h Important: If ite any injury or of		21. Signature of Funeral Service License	Waner		Name and Addre		Balt 1101 E	imore, Md. . North Av	21202 e.	
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the death ne cause on each line. Renal Cel			ng, such as cardiac	or respiratory arre	est,	Approximate Intervat Between Onset and Death MONTINS	
	/Medical Examiner		resulting in dealh) Sequentially list conditions,	Due to (or as a conseq							
8760, <	sate be executed obligation and the burial-transit	dicai Examiner	facy, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq Due to (or as a conseq	·						
.O. Box 68	ne death certific the attending p thed for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □Live birth 2 □ Feta 4 □ Pregnant at time of d	I death 3	Ectopic pregnanc	/		23d. Date of defi Month	very Day Year	
<u>a</u>	quires that the signed by ald be detacted	þ	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the u	nderlying cause gn	ren in Part I.	23e. Did tob	pacco use contribute to es 2 No 3 □ Pri	the cause of death?	
of Vital Records,		Completed						24a. Was ar autops perform 1 Yes 2	y prior to d	lopsy findings available completion of cause of	
Vita	Physician: 1 r this certifical ral director, p	Be	25. Was case referred to medical examiner?	fospital: 1 Inpatient 2	ER/Outpatier	nt 3□ DOA Ott	26. Place of Deat	V	7	cify)	
ion of	1 Yes 2 ANO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 River State of Injury 2 28b. Time of 28c. Injury at 28d. Descrit								Hesidence 6 Uther (Specify)		
Division	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 29e. Place of Injury - At home, farm, street, factory, office 29e. Place of Injury - At home, farm, street, factory, office 29e. Place of Injury - At home, farm, street, factory, office 29e. Place of Injury - At home, farm, street, factory, office 29e. Place of Injury - At home, farm, street, factory, office 29e. Place of Injury - At home, farm, street, factory, office 29e. Place of Injury - At home, farm, street, factory, office 29e. Place of Injury - At home, farm, street, factory, office 29e. Place of Injury - At home, farm, street, factory, office 29e. Place of Injury - At home, farm, street, factory, office 29e. Place of Injury - At home, farm, street, factory, office 29e. Place of Injury - At home, farm, street, factory, office 29e. Place of Injury - At home, farm, street, factory, office 29e. Place of Injury - At home, farm, street, factory, office 29e. Place of Injury - A							28f. Location (St. City or Town	iral Route Number,		
4 Homicide building, etc. (Specify) 2 9a. Certifier (Check only one) 2 9a. Certifier (Check only one) 2 9b. Signature and title of certifier 2 29c. License number 2 9c. License number City or Town, State) City or Town, State) City or Town, State) City or Town, State) 2 9a. Certifier (Check only one) 2 9a. Certifier (Check only one) 2 9b. Signature and title of certifier 2 29c. License number 2 9c. License number 2 9d. Date signed (Month, Day, Year)											
	To the vithin To the comp	M	29b. Signature and title of certifier	h.		29c. Licen:	se number 3759		9d. Date signed <i>(Monti</i> 03-16-2006	h, Day, Year)	
	15		30. Name and address or person who co				Hussain,	M.D.			
	St. Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature #		10 21201				

17. A 19a J 20a	lmr disc res	Sec if an cau that resi	IF F 23b	Part	25.		27.
To Be Completed by Fun		Sertification; To Be Completed by Physician/Medical Examiner	ysician/Me	eted by Pl	e Comp	To B	cation:
Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Iten any injury or other treumetic event. The Medical Examble 2008.	ysician Medical caminer	s after death. I Director: After this certificate has been signed by the attending physician and all brinestor: After this certificate has been signed by the funeral director, page 2 should be detached for use as the burial-transit	s after death. sl Director: After this certificate has been signed by the attending physician and ad in by the funeral director, page 2 should be detached for use as the burial-tran	been signed b should be deta	tificate has tor, page 2	his cer Il direct	s after death. 91 Director: After t 94 in by the funera
Baltimore, Maryland 21215-0036		38760,	Division of Vital Records, P.O. Box 68760, へ	cords, P	tal Re	ž Vi	sion c
Mott, CAth							

	1 - State of Maryland		cate of Death		Reg. No.	306	08154		
cian	1. Decedent's Name (First, Middle, Last) CATHERINE A. MOTT			2. Date of D Month MARCI	Day	2006	3. Time of Death O320 A.M		
dical niner	4a. Facility Name (If not institution, give street and number)	st birthday) If	City, Town, or Location of City, Town, or Location of City Bura Bura Under 1 Year If Under Inths Days Hours	of Death	4c.	County of Death Ne Aa	ur DeL place (State or Foreignty) SYLVANIA		
	Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Locatio	n				10d. Inside City Limits		
ector	MARYLAND HOWARD DAYT		Of. Zip Code		10a Citi	zen of What Cou	1 ☐ Yes 2 🕅 No		
al Dir	4430 OAKWOOD OVERLOOK CT.		21036			ED STAT	-		
To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	If Yes	Decedent of Hispanic Ori s, specify Cuban, Mexican res 2 X No Specify:	gin? (Specify Yes or N , Puerto Rican, etc.)	1	14. Race - Ameri Black, White, Specify: WHI	etc.		
Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12	(Give kind life. DO N	s Usual Occupation of work done during mos IOT use retired) LY WORKER	of working		nd of Business/Ir	,		
To Be Co	17. Father's Name (First, Middle, Last) ANTHONY BALAVAGE		18. Mothe	r's Name (First, Middl (UNKNOWN)			J		
1	19a. Informant's Name/Relationship (Type, Print) J. MICHAEL MOTT / GRANDSON		Idress (Street and Number		-		o Code) 1036		
	20a. Method of Disposition 1 Deurial 2 Tocemation 3 Removal from State	ace of Disposition metery, cremator	(Name of	MARCH 17, 2006	20c. Lo	cation - City or T			
	21. Signifure Aperal Selvice Licensee	22. Na KIR 421	me and Address of Facilit KLEY-RUDDIC CRAIN HWY.	K FUNERAL , S.E., GL	HOME, EN BÛ	P.A. RNIE, MI	21061		
Ec.	23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence)	^	e mode of dying, such as	cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death		
dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen						1 month		
Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Festal 4 □ Pregnant at time of dead 9 □ Unknown	death 3 ⊟Ecto	opic pregnancy er (specify)		2	23d. Date of deliv Month	ery Day Year		
by	Part II. Other significant conditions contributing to death but not resul	lting in the underf	ying cause given in Part I.				he cause of death? bably 4 DUnknown		
Completed				24a. Wa aut per 1 🗆 Yes	s an opsy formed? 2 No		opsy findings available opposed for the control of cause of the cause		
o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ E	R/Outpatient 3	Othor	of Death (Check only		3 □Other (Speci	fv)		
ertification; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year)	6 □Other (Specify) ry occurred							
Certific	3 Suicide 6 Could not be determined 28e. Place of Injury - At hor building, etc. (Specify)	d Number or Rur)	Number or Rural Route Number,						
edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.	e cause(s) , date and	and manner as splace, and due to	stated. to the cause(s)					
Me	29b. Signature, and title of certifier Hem Times Mn		29c. License number DO274	15	29d. Dat	e signed (Month,	Day, Year) 2.00 4		
	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#5, perFH .3854 44/28/06 IT State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend Item #26 Per PHY G853C3/H/H/2016 Amend 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 2006 8:15 AM 03 Hazel Jean Marschke /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Bel Air, Maryland

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Days | Hours | Min. | 01/07/1922 Examiner Harford Catered Living of Bel Air Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 25 F 84 Georgia Director 257-20-3045 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County r then "natural", or Iteme 23s or 28e-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2X No Director Carroll Sykesville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5706 Oak View Drive 21784 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be : 1 and 2 should be fi Health and Mental H tem 27 is marked oti Andrew Jackson Paramore Eva Whaley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5706 Oak View Drive - Sykesville, Maryland of Disposition (Name of Date 20c. Location - City or Town, S Donald L. Marschke (son) 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State = 5 Department of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 03/16/2006 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final INFARCTION Physician MYOCARDIAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HEART DISENSE 1SCHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit HYPER 4 PIDEMIA Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? ģ HYPERTENSION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No OFSTRUCTIVE LUNG DISENSE autopsy performed 1 ☐ Yes 2 No : After this certification a funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Mursing Home 6 □Other (Specify) 1 ☐ Yes 2 🔀 📆 0 ٩ 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Watural 1 Yes 2 No 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) Ander Nowalionshi 19 ARCH 14, 2006

within 24 hours after death. To the Funeral Director: A

filed within 72 hours after

Maryland 21215-0036

Baltimore,

certificate be executed

Box 68760,

o

Records,

of Vital

or Attending

31. Date filed (Month, Day, Year) State MAR 1 7 2006 Registrar

32#Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDREW NOWAKOUSKI

(Barles

125N. MAINST, BEZ AIR, MD 21014

		1- For State of Maryla Registrar		artment of I rtificate of			giene 006	08156
Physic /Med	ical	Decedent's Name (First, Middle, Last) CHARLES D. MARSHALL 4a. Fecility Name (If not institution, give street and number)		4h City Town	or Location of Deat	2. Date of Dea Month	Day Year	3. Time of Death 12:/5/AM
Funera	1	Franklin Square Hospi 5. Social Security Number 96. Sex 7. Age (In y	rs. last birthday) Yrs.	ROS If Under 1 Year Months Days	edale	8. Date of Birth (Month, Day JULY 30	Balti	thplace (State or Foreign ountry)
Directo		Usual Residence of Decedent	City, Town or Lo	ocation		JOSTA 20	,1926 Mar	y Tarru 10d. Inside City Limits
death with the Maryland ms 23a or 28a-f show	ector	Maryland Baltimore	Ва	ltimore	County		10- Civing of Mines C	1 Yes 2 No
h with 1	ai Dir	5318 Glenthorne Ct.		2123	7		10g. Citizen of What Ci USA	ountry
ING KIKIDSOO be filed within 72 hours after death with the Marylan hall Hygiene. In other then "natural, or tems 23a or 28a-f show event, the Medical Examinan must be modified at	by Funeral Director	11. Marital Status 1 Never Married X X Married 3 Widowed 4 Divorced 12. Was Decedent Ever in Armed Forces? X Yes 2 No It Yes, Give Year or Date Core		Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (S van, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whi Specify: Wh	te, etc.
within 72 hours after ene. then "natural", or ite headcal Exercise	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A	(Give	dent's Usual Occu e kind of work done DO NOT use retire ehouse Ma	during most of word)	king	16b. Kind of Business Polyseal	,
should be filed and Mental Hygi imarked other umatic event, I	To Be Co	17. Father's Name (First, Middle, Last) Charles Frederick Marshall			18. Mother's Nar	ne (First, Middle, e e Naomi	Maiden Surname)	
Ma 2 : and 2 : allth ar allth ar 27 is r trau		19a. Informant's Name/Relationship (Type, Print) Christine Marshall (Wife)					r, City or Town, State, , Md. 2123	
		YN Burial 2 Cremation 3 DRemoval from State		osition (Name of matory or other pla Cemeter		-06 B	20c. Location - City or altimore,	
DESILLING permit. Page Department o Important: If eny injury or		21. Signary of Funeral Service Licensee		2. Name and Addr _assahn F	ess of Facility Suneral Ho	amo	7401 Belair Baltimore,	
Physician /Medica		23a. Part1. Enter the disease, or complications that caused the d shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	0 1.	ratory a	ing, such as cardial	or respiratory arm	est, 'ME	Approximate Interval Between Onset and Death
It be executed the executed by yesicien and burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conditional property of the conditional property of the conditional property of the conditional property of the conditional property of the conditional property of the conditional property of the conditional property of the conditional property of the conditional property of the conditional property of the conditional property of the conditional property of the conditional property of the conditions of the conditional property of the conditio				<i>O</i>		
death death ad for a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pre 1 Live birth 2 Femant at time 6 9 Unknown	etal death 3	□Ectopic pregnand □ Other (specify)	ey		23d. Date of de Month	Nivery Day Year
wequires that the been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not	resulting in the u	undertying cause g	ven in Part I.	23e. Did to	bacco use contribute to	o the cause of death?
I KeC The law ete hes b	Completed					24a. Was a autop perfor 1 □ Yes	24b. Were a prior to death?	utopsy findings available completion of cause of
VICAL Prescient The scartificate	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 X Inpatient 2	2 ☐ ER/Outpatie	nt 3□ DOA Ot	hor	th <i>(Check only or</i>	ence 6 Other (Spe	acifu)
UNVISION OF VITA To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	28b. Time o	of 28c. Inju			ow injury occurred	
LIVISION at or Attending s after death. It Director: Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Sp.	it home, farm, st ecify)	reet, factory, office		28f. Location (S City or Tow	Street and Number or A m, State)	dural Route Number,
ne Hospit n 24 hour ne Funera	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my 2 Medical Examiner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	th occurred at the to nvestigation, in my	ime, date and place opinion, death occu	, and due to the d rred at the time, o	ause(s) and manner a date and place, and du	s stated. e to the cause(s)
To the within To the comp	W	29b. Signature and title-objectified		29c. Licen	se number	28	29d. Date signed (Mon March	th, Day, Year)
511		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) Sak	Jate Tri	ve Bal	timore. M	d 21237
S Regis	tate trar	31. Date filed (Month, Day, Year) 32. Registrar's Si	gnature	20) '	

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 13 2006 1:45am M March Jackson Woodrow Maslin. Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Sunrise Assisted Living Gaithersburg 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 M 2 □ F Yrs Director 10/12/1912 Maryland 579-58-0601 Usual Residence of Decedent the Maryland 10a. State 10c. City. Town or Location 10d, Inside City Limits 10b. County or 28a-1 show traumatic event, the Medical Extrobar must be notified at WYes 2 No Director MD Prince Georges College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with ti Department of Health and Mental hygiene. Important: If tem 27 is marked other than "n-1" any highy or other traumatic. 20740 USA 7506 Creighton Drive Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: White Specify: 3 ☑ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) U.S. Government 2 years Internal Revenue Service 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sallie Rauscher 0 Frank S. Maslin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20600 Hazelnut Ct., Germantown, MD 20874 Jackson W. Maslin, Jr. - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) West Chester. PA R.A. Ferris & Co. 03/15/06 21. Signature of Funeral Service Licenses Mitchell-Smith Funeral Home, P.A. Maure 123 S. Washington, Havre de Grace, MD 21078 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ocardial min /Medical Examiner pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown cate has been signed page 2 should be der Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Donknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? (es 2 No 1 ☐ Yes or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ EB/Outpatient 3 ☐ DOA After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier March 30. Name and address of person who cam 1 leted cause of death (Item 23a) (Type, Print) 15215 Shady Grove Rd., Rockville, MD 20850 Suhair Abulfarag. 31. Date filed (Month, Day, Year) 32., Registrar's Signature State MAR 1 7 2006 Registrar

Kiam A. Moody 06-01814 CT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

71014	1- For State of Maryl	and / Department of Health and Certificate of Death	Mental Hygiene
	Decedent's Name (First, Middle, Last)		2. Date of Death 3. Time of Death
Physician /Medical	Kiam Anjiro Moody		March 14 2006 12:50 A ^M
Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	
	Johns Hopkins Hospital 5. Social Security Number 6. Sex 7. Age (In	Baltimore yrs. last birthday) If Under 1 Year If Under 24 Hr	N/A S. 8. Date of Birth 9. Birthplace (State or Foreign
Funeral Director	212-72-7996 XXM 2 F	Months Days Hours Min	
70	Usual Residence of Decedent		
nrylan show		. City, Town or Location	10d. Inside City Limits
vith the Mar t or 28a-f st be mutified Director	MD Baltimore 10e. Street and Number	Randallstown	1 ☐ Yes 2 ☒ No
th with with all D	4301 Travancore Road	21133	USA
Baltimore, Maryland 21215-0036 Department of Health and Les be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. In marked other than "natural", or iteme 23a or 28a-1 show mortant: if ten 27 is marked other than "natural", or iteme 23a or 28a-1 show any injury or other traumatic event, if a Medical Example or must be invitilled at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Yes, Give A Year or Dates:	in U.S. 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue 1 Yes 2 No Specify:	Specify Yes or No- orto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: African- American
2 hours satura	15. Decedent's Education	16a. Decedent's Usual Occupation (Give kind of work done during most of w	16b. Kind of Business/Industry
21215-00 ed within 72 hos ygiene. ner than "natura. it, Ira Madical Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	3
d 2121 filed within Hygiene. ther than out, ILE WE	12th	Mechanic	Auto Shop
be fill Hall Hall Hall Hall Hall Hall Hall H	17. Father's Name (First, Middle, Last)		ame (First, Middle, Maiden Sumame)
laryland 212: 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, I.a.M. To Be Comp	Donald Moody 19a. Informant's Name/Relationship (Type, Print)		n Gyral Martin Gural Route Number, City or Town, State, Zip Code)
Maryland d 2 should be file th and Mental Hy i'i is marked oth traumatic event To Be (Karen Scott/Mother		d., Randallstown, MD 21133
tem 2		Db. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
Baltimore, semit. Pages 1 a Department of Hee mportant: if item not injury or othe unce.	1-E buttal 2 Constitution 3 Enternoval from State	·	18/06 Woodlawn, MD
Baltimo	21. Signal of Funeral Service Licensee		vlie F/H PA of Balto. Co.
m 88 E 8 8	Mander Milling	9200 Liberty Ro	d., Randallstown, MD 21133
	23a. Part1. Enter the disease, or complications that cause the shock, or heart failure. List only one cause on sach ne.	death. Do not enter the mode of dying, such as cardi	Interval Between
Physician //Medical	Immediate Cause (Final disease or condition resulting in death)	, Nound of Ches	Onset and Death
Examiner	Due to (or as a cor	nsequence of):	
ē interest	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(эвериялия of).	
executed in and ital-transit	Cause. Enter Undertying Cause (Disease or injury that initiated events		
760, ve executed sician and burial-transit	resulting in death) Last Due to (or as a con	nsequence of):	
(8760, cate be ex physician the burial dical Ex	d		
I Records, P.O. Box 68760, The law requires that the death certificate be executed atte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit completed by Physician/Medical Examir	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant		23d. Date of delivery
death death of death of a tree ad for sicia	in the past 12 months? The past 12 months 1 Live birth 2		Month Day Year
p.O. I that the de that the de detached is detached if	9 Unknown		
ds, P	Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
of Vital Records, Physician: The law requires to this centificate has been signe and irector, page 2 should be a transfer to the Completed by			24a. Was an 24b. Were autopsy findings available
I Rec			autopsy prior to completion of cause of death?
Vital Figures The certificate rector, page Color Be Color	25. Was case referred to medical	26 Place of D	eath (Check only one)
of Vita Physician: this certific al director, To Be (examiner? 1XXYes 2 □ No Hospital: 1 □ Inpatient	Other	Home 5 Residence 6 Other (Specify)
Vision of Vital Attanding Physician: ordeath. or	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Yea	28b. Time of 28c. Injury at Work?	28d. Describe how injury occurred
ision ttsndir death. ctor: Al y the fu	2 Accident investigation	1 Yes 2 No	Subject 8 tohed
Division c tal or Attending P sa after death an Divector: After t ed in by the funera Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (St	At home, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
pital curs a small billed i	Continue Description Description To the board	STREET	(000 BK WEBLET, 71202
Division of To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one) (Check only one) 1 Certifying Physician: To the best of my 2XMedical Examiner: On the basis of examiner one) and manner stated.	knowledge, death occurred at the time, date and plan mination and/or investigation, in my opinion, death occ	ce, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)
Me Me		29c. License number	29d. Date signed (Month, Day, Year)
2323	() (sheard)	OCME	March 14, 2006
2	30. Name and address of person who completed cause of death		
0.	J. HON LOCKE M)	111 Penn Stre	et Baltimore, Maryland 21201
State	31. Date filed (Month, Day, Year) 32. Resistrar's S	ignature	· · · · · · · · · · · · · · · · · · ·
Registrar	MAR 1 7 2006	13 Species	
DHMH 17 Rev 1/2001		ORIGINAL	

			1 - For State Registrar	State o	f Marylar		artment of F		nd Mental Hy	giene Reg. No.	2006	08159
	Physici	an	Decedent's Name (First, Middle, I YURIY	.ast)			MAYYER		2. Date of Dea Month MARCH	Day	2006	3. Time of Death 11:42A M
>	/Medic Examin		4a. Facility Name (If not institution, g				4b. City, Town, o	r Location of			County of Death	11.428
			3809 CLARKS LAI 5. Social Security Number 6.	NE APT.		lact hirthday)	BAL7	IMORE	LHrs 9 Date of Riv	b	N/A	place (State or Ferring
	Funeral Director		216-47-9662	1√M 2□F	7. Age (<i>In yrs</i> . 58	Yrs.	Months Days	Hours	Min. 8. Date of Birt (Month, Da 06/09/1	947	9. Birth Cou	place (State or Foreign ntry) UKRAINE
Ī	land		Usual Residence of Decedent 10a. State 10b. County	11	10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
	e Mary	ctor	MD N/A		В	ALTIMO	RE					1 No 2 No
	with th	Director	10e. Street and Number 3809 CLARKS LA	NF APT	#201		10f. Zip Code 21215			10g. Citiz	en of What Cou	intry?
	death	Funeral	11. Marital Status		edent Ever in U	.S. 13.		lispanic Origin	n? (Specify Yes or No Puerto Rican, etc.)	- 1	4. Race - Ameri Black, White	
30	72 hours after death with the Maryland "natural", or theme 23a or 28a-f show sdical Evantinat must be notilled at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced		2 No /e X	í	1 ☐ Yes 2 🗖 No	Specify:			Specify: WHI	
2-003p	72 hou 'natura		15. Decedent's (Specify only highest of	Education		16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most o	of working	16b. Kin	d of Business/Ir	ndustry
121	within lene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired NEER	d)		ELE	ECTRI CAL	
	be filed tal Hyg d other	Be	17. Father's Name (First, Middle, La	st)		MAYY		18. Mother's	s Name (First, Middle,	Maiden S		PISMANIK
ary ia	should nd Men marks imatic	ဥ	VLADIMIR 19a. Informant's Name/Relationship	(Type, Print)		19b. Mailii	ng Address (Street	and Number	or Rural Route Numbe	er, City or	Town, State, Zi	o Code)
, M	and 2 ealth a m 27 is		LYDMILLA MAYYE	R / WIFE		3809	CLARKS I	_ANE AI	PT. #201 -	BALT	rimore,	MD 21215
nore	ages 1 ar ant of Hea at: If item y or other		20a. Method of Disposition 1 Disposition 1 Disposition 3 Cremation 3 4 □ Donation 5 □ Other (Special Contents)		State	cemetery, crei	osition (Name of matory or other place HFRRFW (Date 3/16/2006		ation - City or T	
altil	permit. Pag Department important: I eny injury o		21. Signature of Funeral Service Lic	• •	111	22	2. Name and Addre	ss of Facility	SOL LEVI	NSON	& BROS.	INC.
D —	g Q ;		23a. Part1. Enter the disease, or co	mulications that of	the deal	-			OWN ROAD -		SVILLE	Approximate
R	Physician /Medical Examiner		shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on e	ach line.	atic	vectal	-			4	Interval Between Onset and Death
8/00, A	icate be executed physicien and s the burial-transit	dical Examiner	Social field list on citiens if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to c.	(or as a conseq							
O. Box 68	certif iding	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1☐Live t	come of pregna pirth 2 Feta nant at time of c own	Ideath 3	□Ectopic pregnancy □ Other (specify) _	/		2:	3d. Date of deliv	rery Day Year
rds, P	w requires that the death been signed by the atter should be detached for u	ξ	Part II. Other significant conditions	contributing to d	eath but not res	ulting in the u	nderlying cause giv	en in Part I.		obacco us res 2 🗆		the cause of death?
al Kecord	The law ete has b page 2 st	Completed							24a. Was autop perfo 1 🗆 Yes		24b. Were autoprior to codeath?	opsy findings available ompletion of cause of
VII	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	Inpatient 2	ER/Outpatier	oth	00	of Death Check only only only only only only only only		Other (Speci	4.1
lon of	ng Phy fter this ineral d	<u> - </u>	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date (Mon		28b. Time o Injury	f 28c. Injur	4 Nurs	28d. Describe h		- ''	īy)
DIVISION	Dir afte	Certification:	3 Suicide 6 Could not determine	d 286. Place	of Injury - At h	ome, larm, st	reet, lactory, office		28I. Location (S City or Tov		Number or Rur	al Route Number,
	ne Hospital n 24 hours a ne Funeral eletely filled	edical (29a. Certifier 1 Scertifying (Check only one) 2 Medical Ex	aminer: On the b	best of my kno asis of examina ner stated.	owledge, deat ation and/or in	h occurred at the til vestigation, in my o	me, date and pinion, death	place, and due to the occurred at the time,	cause(s) a date and	and manner as s place, and due t	stated. to the cause(s)
•	To the within 2 To the comple	Me	29b. Signature and/title of certifier	Ml	ole	MD	29c. Licens	e number 3589		29d. Pate	signed (Month)	Day, Year)
	ń		30. Name and address of person who Nancy Vander V	o completed caus	se of death (Iter	n 23a) (Type,			re Balti	mor	e MD	21215
か	Sta Registr		31. Date filed (Month, Day, Year) MAD 1 7	- 3	gistrar's Signa	ature	and the					

State of Maryland / Department of Health and Mental Hygiene

				Otato of Ma	arylana /				Death		Reg. No. () ()	0.8	60_
•			1. Decedent's Name (First, Middle, Las	it)						2. Dete of De Month			of Death
	Physiciar /Medica		Ruth Man	rie Nelson						March	13, 2006	3:2	O PM
A STATE OF	Examine		la Fecility Neme (If not institution, give		_				4b. City, Town, or L				
aght in			Shady Grove Adven	tist Nursi	ing Ce	nter			Rockvi		Montgom		
	Funeral Director		072 12 7510	ex 7. Age □ M 2只 F 8	e (In yrs. lest	birthday Yrs.		Deys	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da October	10, 1921 Ne	Birthplece (State Country)	ey
	P	- 1-	Usuel Residence of Decedent 10a. Stete 10b. County		10c. City, To	own or L	ocation					10d. Inside	City Limits
	Aaryi A	5	Maryland Montgom	erv	Pot	omac						1 □ Y	es 2 □ No
	the the table	Director	10e. Street end Number	017				o Code			10g. Citizen of What	Country?	
	ier death with the Marylen ferre 23a or 28a-f show ner must be notified at	5	7785 Heatherton	l.ane					20854		United St	ates	
	le ath	<u>e</u> a	11. Merital Status	12. Wes Decedent E	Ever in U,S.	13.	Was Dece	dent of I-	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No	- 14. Race - A	merican Indian	,
Maryland 21215-0020	urs af	by Fur	1 Never Merried 2 Married 3 ☑ Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Detes:	ło		If Yes, spe			Hican, etc.)	Black, W	White White	
5-0	72 h		15. Decedent's Ed (Specify only highest gra	ucetion de completed)	1	6a. Dece	edent's Usu	al Occup ork done	eation during most of world)	king	16b. Kind of Busine	ss/Industry	
7	thin o	Completed	Elementery/Secondary (0-12)	College (1-4or 5	+)			ise retire	d)		O II	_	
7		5	12		I	lome	maker		45.54.01.1.51	- 15:> 0 0:-1-11	Own Home	;	
n d	ET SE	IO Be	17. Fether's Neme (First, Middle, Last)							and the second	, Maiden Surname)		
Z	Para E	2	Randolph Major			200 11 12	2002000			Anderso		7:- 0-4-1	
Jar	2 sh end le m	1	19a. Informent's Name/Relationship (7	ype, Print) Former							er, City or Town, State		./ı
	m 27	- 16	Elizabeth B. Witte	er/Daugnter-						7	20c. Location - City		
Baltimore,	Peges 1 ment of H ant: If Ite		20a. Method of Disposition 1 ☐ Burial 2 【A Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			omery		oriun	n, Inc.	larch 5, 2006	Bethesda,	Maryla	
Ball	pemit. Peg Department Important: f any injury o	I	21. Signature of Funeral Service Licen	nute MO	1305	30	00 West	Mont	gomery Aver	nue, Rock	/Rockville, : ville, Maryl		0–2805
			23a. Pert 1. Enter the diseese, or comp shock, or heart failure. List only	olications that caused	the death. I	Do not er	nter the mo	de of dyir	ng, such es cardiac	or respiratory a	rrest,	Approxir Interval I	nate Between
	Physician /Medical Factoriner		Immediate Cause (Final disease or condition resulting in deeth)	ө	Due to (or es	Va	rce	9	Den			Onset a	nd Death
	D = 1	2											
6	rificate be executed by physician and as the burial-fransit		Sequentially list conditions,	D.	Due to (or as	a conse	зцивнив ођ						- 0
68760,	e excision a vuriai.		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C									
87(sate the the the the the the the the the t	edical	that initiated events resulting in death) Last		Due to (or as	a conse	equence of)	:				į	
9 ×	는 일찍 등	₽		d									
Box	eath cert ettending i for use	를											
o.	that the dended by the ended of	Physician/M	Part II. Other significant conditions of	ontributing to death bu	ut not resultin	ng in the	underlying	cause gi	ven in Part I.		tobacco use contrib		
<u>α</u>	hat the by detac									10	Yes 21110 3	Probably 4	Unknown
Records,	2 55 4	2								24a, Wes	en autopsy 24	b. Were autop	sy findings
Ö	v require been signation									perfe	ormed?	aveilable pri completion of death?	or to of cause
3ec	The lew ate has be page 2 s	Completed											
<u>e</u>	cate ha	_									Yes 2 410	1 ☐ Yes :	21 NO
Vital	5 5 C	ן מב	25. Wes case referred to medical examiner?	Hospital:			-5-	Ot	26. Place of Dea				
to	this eld	<u></u>	1 Yes 2 No 27. Manner of Deeth	1 L Inpatie		/Outpation		OA	4 Latriursing H		idence 6 Other (S how injury occurred	респу)	
	Ing P After funer	5	1 ☑Naturel 5 ☐ Pending	28a. Dete of Injui (Month, De)	y Year)	Injury	M	28c. Inju Wo	rk?]Yes 2 □ No		,,,,,		
2	Attending or death.	Cal	2 Accident investigetion 3 Suicide 6 Could not be		uny - At home	a farm s				28f. Location	(Street end Number or	r Rural Route I	lumber,
Division	or Atter of Direction by	Certification:	4 ☐ Homicide determined	building, etc	c. (Specify)	, (4,,,,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	.,,		City or To	iwn, Stete)		
			29a. Certifier 1 Certifying Ph	ysicien: To the best of	of my knowle	dge, dea	ath occurred	d at the ti	me, date and place	, and due to the	cause(s) end manner date and place, and	r es steted.	se(s)
	ne Ho ne Fu oletel	edicai	(Check only 2 Medical Exam	end manner sta		enovori	investigatio	n, in my t	opinion, death occu	rreg at the time,	, date and place, and t	Jue to the caus	
_	Withir Comp		29b. Signeture and title of certifier	-			29	c. Licen	se number	22	29d. Date signed (M	onth, Day, Yea	r)
			1		-	Z		M	11 383	7+	0>/14)	06	
	10	Ł	30, Name end eddress of person who	completed cause of d	leeth (Item 23	За) (Туре	e, Print)	2607	, 2nd Are	· Kulle =	404B		
	(-		011 (11	evar, MD				Silv	rerspring.	OC CIM	910		
	State Registra	e	31. Dete filed (Month, Dey, Year)	2006 32. Registre	er's Signatur	0	beech	5	.)				

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 19b per fh 8853 3-17-06 vt.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Ρ. MARY MARCH 11:15 A NIEMAN 15, 2006 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SINAI HOSPITAL BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 8. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 11/25/1908 Birthplace (State or Foreign Country) Days Months Hours 1 □ M 2 🛛 F 063-52-3059 97 Vrs IL. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1**V** Yes 2 □ No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2007 W. ROGERS AVENUE 21209 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, et 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 Yes 2 No WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BANK TELLER FIRST NATIONAL BANK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) PINCUS PEARL ROSE UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number HOUSDON lumber, City or Town, State, Zip Code) 2628 SUNSET BLVD. - HUSTON; TX 77005 LAWRENCE NIEMAN / SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BNAI ISRAEL 03/16/2006 CHEEKTOWAGA, NEW YORK 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock for healt failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death RUSPINATON MILURO MM 201175 Due to (or as a consequence of) SPIRATION MMONITI I hour Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ◯ No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Oate of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident
 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit s efter death.

Physician

/Medical

10a State

MD

Director

Funeral

ģ

Completed

Be

Examiner

Funeral

Director

r then "natural", or iteme 23s or 28s-f ehow the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other then eny injury or other traumatic event, the Magnes.

Physician

/Medical

Examiner

by Physician/Medical

Completed

Be

٩

Certification:

Medical

29a. Certifier

within 72 hours after

Baltimore, Maryland 21215-0036

8

State Registrar

Uhion 31. Date filed (Month, Day, Year)

29b. Signature and title of centifier



30. Name and addre is of prison who completed cause of death (Item 23a) (Type, Print)



Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29g, License number

12 1039

29d. Date signed (Month, Day, Year)

MD 2/109

106

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician 6:30 P M JOHN L. OSTROWSKE MARCH 10, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner MARINER HEALTH OF GLEN BURNIE GLEN BURNIE ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day, Year)
NOV. 22, 1 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 75 232-36-8529 1930 WEST VIRGINIA Director Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State in than "natural", or Itema 23a or 28a-f show the Modical Examiner must be notified at MARYLAND 1 Yes 2 No BALTIMORE COUNTY LANSDOWNE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2710 NORFEN RD. 21227 UNITED STATES o filed within 72 hours after death vil Hygiene.

other than "natural", or Itema 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify:WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) BUS DRIVER TRANSPORTATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill iment of Health and Mental H lant: If item 27 is marked other. WALTER OSTROWSKE ROSA WAUGAMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SARA V. OSTROWSKE/WIFE 2710 NORFEN DR., BALTIMORE, MD 21227 MARCH 18 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ B Fial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Gt. (Specify) permit. Page Department o Importent: If any Injury or once. BUCKHANNON, W. VIRGINIA MT. UNION CEMETERY 2006 21. Signature of Fyrantil Service Licens 22. Name and Address of Facility
KIRKLEY-RUDDICK
FUNERAL HOME, P.A.
421 CRAIN HWY., S.E., GLEN BURNIE, 3 MD 21061 Approximate Interval Between Onset, and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DEMENTIA **Physician** 3 YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe THEUMONI 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No репогм<u>е</u>d? 1□ Yes 2☒ No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death | Check only one) Other: 4 🖔 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) Hospital: 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA Certification: To t) After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours after To the Funeral Dire 29a. Certifie 1🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of ce differ 29c. License number 29d. Date signed (Month, Dey, Year)

Baltimore, Maryland 21215-0036

P.O. Box 68760,

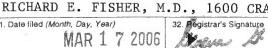
Division of Vital Records,

State Registrar

31. Date filed (Month, Day, Year) MAR 1 7 2006

Lace

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)





D 02519

MARCH 13, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** March 9, 2006 Meera Pal 5:08 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, Year) December 27, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex **Funeral** Min Months Days Hours Country) India 1 □ M 2 🖾 F 51 1954 212-98-6250 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County h and Model Hygiene.
7 is marked other than "natural", or fems 23s or 28s-1 show traumatic event, the Model at Express man the colline at 1 ☐Yes 21 No Director Gaithersburg Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? filed within 72 hours after death with 12235 Galesville Drive 20878 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Asian Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Programmer Data Processing permit. Pages 1 and 2 should be filed.
Department of Health and Mental Hygi important: if Item 27 is marked other any injury or other traum-**: 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Atal Behari Pal Rajabala Pal ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ranajit Pal/ Brother 627 Lavenham Court, Timonium, Maryland 21093 20b. Place of Disposition (Name of Montgometry, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State March 11, 2006 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Crematorium, Inc. Bethesda Chevy Chase, Inc. Pump Bethesda, Maryland 20814-3501 21. Signature of Funeral Service ticense Pumphrey Funeral Home/ MO1386 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nmediate Cause (Final **Physician** Asphyxiation disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Depression Sequentially list conditions, and the desired to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.0. the detached 9☐ Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ pe 1 Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a Wasan certificate has rmeg≀ 2. <mark>A</mark>No 1 ☐ Yes Physician: Be 25. Was case referred to medical 26. Place of Death [Check only one] examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 →Yes 2 □ No b 2 Pis 28a. Date of Injury (Month, Day Year) March 9, 2006 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attending 1 Natural 4:43 P M 5 Pending death. 1 Tyes 21 No Hanging 2 Accident investigation Director: 6 Could not be determined 3 X Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Home 28f Location (Street and Number or Rural Route Number, City or Town, State) 12235 Galesville Drive, Gaithersburg, MD after 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D51916 March 9, 2006 Fatricia 10ms/c 30. Name and address of person who completed cause of ath (Item 23a) (Type, Print) 9 Patricia Tomsko Nay. M.D., 1119 Rockville Pike, G-100, Rockville, Maryland 20852

State Registrar

MAR 1 7 2006 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

		For State	State of M	aryland		rtment of H		Mental Hy	giene	ne	00165
		Registrar 1. Decedent's Name (First, Middle, I	Last)		Oei	incate or i	Jean	2. Date of D		10	3. Time of Death
Pٌhys		Margaret Et		3				Month MCIr.	Day 13	2006	4:30 A M
/Me	dical	4a. Facility Name (If not institution, g				4b. City, Town, or	Location of Death			y of Death	, , , , , , , , , , , , , , , , , , , ,
LAdii	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Bellir Health	ad Rehabil	tation	Cent	er Be	1,4:1-		tt	arc	ord
Funer	al		. Sex 7. Aç	ge (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	rth ay, Year)	9. Birthp	place (State or Foreign
Directo	or	406-28-7936	1 □ M 2 🔀 F	89_	Yrs.			July 9	, 1916	Kent	ucky
and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation		<u></u>		1	0d. Inside City Limits
Marylan -1 show	ţ	Marvland Harfor	v3	Bo T	L Air						1 ☐ Yes 2 🔯 No
r 28a	Director	10e. Street and Number	<u>u</u>	ı De-	LALL	10f. Zip Code			10g. Citizen of	What Cour	ntry?
th with		555 S. Atwood	Road Apt.	417		21014	l		USA		
ams serme	Funerai	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S	i. 13. \	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puert	pecify Yes or No Rican, etc.)		ce - Americ	
36 or its	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give	No		☐ Yes 2√2 No	Specify:		Spec	ify:	
1215-0036 within 72 hours after death with the Maryland ene. Than "natural", or items 23a or 28a-f show the Medical Evantiner must be recitified at	d be	15. Decedent's	Year or Dates:		16a Decec	lent's Usual Occupa	ation		16b. Kind of I	Whi Business/Ind	
115 in 72	Completed	(Specify only highest	grade completed)	5.1)	(Give life. L	kind of work done of NOT use retired	during most of wor	king			,
212 d with giene.	l wo	Elementary/Secondary (0-12)	College (1-4or	5+)	Booke	eper			U.S. G	overn	ment
Ind 21215-0036 be filed within 72 hours after death with the Maryla Math Hygiens and other than "natural", or litems 23s or 28s4 show event, the Medical Examiner must be invitibled at	Be	17. Father's Name (First, Middle, La	st)			_	18. Mother's Nan	ne (First, Middle		me)	
aryland 2 should be filed nd Mental Hygi marked other umatic event,	2	Jesse (unk) Ko	llenberg				Belle	(unk)	Hicks		
Aar 2 sho 1 and 18 m		19a. Informant's Name/Relationship				g Address (Street a					
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours att Department of Health and Mental Hyglines are important: if itam 27 is marked other than "natural; or any injury or other traumatic evant, the Medical Evant any injury or other traumatic evant.		Ronald O. Pennsy	Te/ Son	20b. Pl				Date	20c. Location		
ages to the		1 ☐ Burial 2X Cremation 3		9		sition (Name of natory or other place	1			·	
altin mit. Pa spartme sportant		4 ☐ Dorfation 5 ☐ Other (Spe	1	HIL		ervice Co ccomas fi			Towson,	мату	Land
Ba Perm Impo	SUCE	THE MY	111			317 Cokes				iarvla	nd 21009
		23a. Part 1. Enter the disease, or co shock, or heart failure. List or	omplications that cause	d the death					_		Approximate Interval Between
Pnysicia	me i	Immediate Cause (Final disease or condition	4/10	1.0	C 10	-	ahon	. X	Dirani	los	Onset and Death
/Medic	al	resulting in death)	Du to or as	s a conseq	ence of):	- ym	Prent	1	Crown	a	HOAINS
Examine	8	Sequentially list conditions,	b								
a N Be is	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	э а аспанци	ienes sty:						
xecut xecut	хап	that initiated events resulting in death) Last	c. Due to (or as	s a consequ	ence of):						
8760, % sate be executed hysician and the burial-transit	dicai E										
687 ifficate g physias the	edic		u	Marie Same							
XX XX XX XX XX XX XX XX XX XX XX XX XX	M/u	JF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth	e of pregnar	ncy death 3	Ectopic pregnancy				ate of delive	*
O. B See death the attr	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant a			Other (specify)			N	lonth	Day Year
S, P.O. Bost that the death gned by the atte	by Physician/Me	9 Unknown			let to 4b			ggo Did	tobacca uso co	atributa to t	he cause of death?
Records, P. The law requires that the has been signed be age 2 should be deta	by	Part II. Other significant condition	s contributing to death	but not resu	iiting in the u	nderlying cause giv	en in Fan I.	4	Yes 2 No	3 □ Prob	
Cord wrequir been si	Completed							24a. Wa			opsy findings available
de law	ig m							aut	opsy formed?	prior to co death?	impletion of cause of
Vital B iclan: The certificate		OS Man and referred to medical					OC Diseased Dec	1 Tes		1 🗆 Yes	2 No
of Vita Of vita Physiclan:	o Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpat	tient 2∏I	ER/Outpatier	t 3 DOA Oth	er: ursing h		sidence 6 🗆 O	ther (Specif	fv)
nんらり / C Sion of Vital Re tending Physician: The leath. tor: After this certificate hat the funeral director, page	n: To	27. Mann f Death	28a. Date of Inj (Month, D		28b. Time o		v at		how injury occu		
Vision of Attanding Frideath.	atio	1 atural 5 Pending investiga	tion	ay rour,	injury		Yes 2 □No				<u> </u>
Divisi Divisi I or Attar after dea Diractor	Certification;	3 Suicide 6 Could no 4 Homicide determin	286. Place of it	njury - At ho etc. <i>(Specif</i> y	me, farm, str	eet, factory, office		28f. Location City or To	(Street and Nun own, State)	nber or Rura	al Route Number,
Spital o										8	
To the Hospital within 24 hours a To tha Hours a Completely filled	edicai	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the bes xaminer: On the basis and manners	of examinat	wledge, deat ion and/or in	n occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	e, and due to the arred at the time	e cause(s) and r e, date and place	nanner as s e, and due t	rated. o the cause(s)
To the Hos within 24 h To tha Fur completely	Med	29b. Signature and title of certifier	and mariners			29c. Licens	e number		29d. Date sign	ned (Month,	Day, Year)
- F 3 F 8		· Man	mal MI		10	Di	GETES		Maria	61	3 2001
^		30. Name and address of person w	ho completes cause of	death (Item	23a) (Type,	Print)	7785	×	2010	4	1
4		Manuel +	1. Lazo	thi	ND	8	Lain ST	. / 10	MADO	er	1 dry land
**	State	31. Date filed (Month, Day, Year)		trar's Signa	ture	2			100)	/	(
Reg	istrar	MAR 1 7 20	30 Restar	2000	1						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item I per doc 8853 3-17-06 vt. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Zoey Anne Pulling Villhelm 2. Date of Death **Physician** Month Year 1:53 March 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bayview Medical Center Baltimore, Baltimore Johns Hopkins If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 X M 2 □ F Yrs. 50 Jan. Director 214-62-9017 Maryland 4,1956 Usual Residence of Decedent with the Maryland 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits other then "natural", or Iteme 23a or 28a-f show vent, the Medical Examiner must be putified at 1X Yes 2 □ No Baltimore Funeral Directo Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1102 Quantril Way 21205 u. s. A. Pages 1 and 2 should be filed within 72 hours after deeth Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Health Care Nursing Assistant 12th Grade permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If Item 27 Is marked other th any Injury or other traumatic event, ITE DDEB. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elena Letra Burr Pulling ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Burr Pulling (Father) 1038 Lerew Way, Baltimore, Maryland 21205 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gardens 3/17/2006 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 1 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End stage rena /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) ettending physician for use as the buria Division of Vital Records, P.O. Box 68760 Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death signed by tha eld be detached for 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate 1 XYes 2 🗌 No director, 25. Was case referred to medical examiner? To Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 MInpatient 2 ☐ ER/Outpatient 3□ DOA this After this 27. Manner of Death 28c. Injury at Work? Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: completaly filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) RES-000 HIAMBELL 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

Jeffrey

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2006

4940 EASTERN AVENUE BALTIMORE, MD 21224

			_ POI	State of Maryland / Dep	partment of Health and	Mental Hygie	ne
		_	- State Registrar	C	ertificate of Death	Reg.	
	Physicia		Decedent's Name (First, Middle, Last) OLEG		POSPELOV	Month	Day Year 14, 2006 12:44P. M
	/Medic Examin		4a. Facility Name (If not institution, give str	reet and number)	4b. City, Town, or Location of Dear	<u> </u>	4c. County of Death
	LAGIIIII		Rt. 140 @ GLENN FALI		REISTERSTOWN		BALTIMORE
	Funeral		5. Social Security Number 6. Sex 1218-41-0229	7. Age (In yrs. last birthda 46 Yrs.	y) If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthplace (State or Foreign Country) RUSSIA
	Director		Usual Residence of Decedent			O-7 03/ 133	
	arylan ehow	_	10a. State 10b. County	10c. City, Town or			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	1he M	Director	MD BALTIMOR	RE BALTIM	IUKE 10f. Zip Code	10g	. Citizen of What Country?
	h with	io ie	ONE FRIENDSWOODS	CT. # 1-A	21209		U.S.A.
	ems 2	Funeral	11. Marital Status	Armed Forces?	3. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f ehow fre Madical Exertible mail be notified at	by F.	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	1 ☐ Yes 2 🕅 No Specify:		Specify: WHITE
21215-0036	72 hou	ted	15. Decedent's Educa (Specify only highest grade	ation 16a. De	cedent's Usual Occupation we kind of work done during most of wo		b. Kind of Business/Industry
215	hen 'r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	a. DO NOT use retired)		OME IMPROVEMENTS
d 22	Hygie Hygie other t		12 17. Father's Name (First, Middle, Last)	CONT	TRACTOR 18. Mother's Na	me (First, Middle, Ma	
lan	Mental Mental rked o	То Ве	DMITRY	PC	SPELOV NINA		UNKNOWN
Baltimore, Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylan It of Heelih and Mental Hyglene. If item 27 is marked other then "naturel", or items 23e or 28e-f show or other treumatic event, the Madical Examiner meatice notified at		19a. Informant's Name/Relationship (Type		ailing Address (Street and Number or F		
e, N	s 1 and 2 of Heelth a item 27 is		LYUDMILA POSPELOV 20a. Method of Disposition	20b. Place of Dis	FRIENDSWOOD CT. #	THE THE PARTY OF T	c. Location - City or Town, State
nor	ages ant of nt: If it y or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State HAR SINA	rematory or other place)	16/2006 OW	INGS MILLS, MD 21117
altii	permit. Pages 1 an Department of Heel Importent: If Item 2 eny injury or other ansa.		21. Signature of Funeral Service Licensee		22. Name and Address of Facility	OL LEVINSO	N & BROS., INC.
8	82 = 8		- Scett M.	Mu			KESVILLE, MD 21208
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	ations that caused the death. Do not be cause on each line.	* *	ic or respiratory arresi	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence of):	Injuries		
	Examiner		Sequentially list conditions, b.				
19	be isit	niner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a nonsequence of):			
1/2	execut n and ial-trar	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence of):			
8760,	The law requires that the death certificate be executed at hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	edicai	d.				
9	eath certific: attending pl	/Med	IF FEMALE: 23	c. If yes, outcome of pregnancy			23d. Date of delivery
Box	death of attended for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
P.0	that the de ted by the detached	Phys	9 Unknown	9∐ Unknown		22a Didasha	and the court of death?
	ires th signed	Ď	Part II. Other significant conditions cont	nbuting to death but not resulting in th	e underlying cause given in Paπ I.	1 ☐ Yes	cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown
cor	w requir been si should	letec			-	24a. Was an	24b. Were autopsy findings available
Re	The lavele hes	Completed				autopsy performe	prior to completion of cause of death? ☐ No 1 🛣 Yes 2 ☐ No
Vital Records,		BeC	25. Was case referred to medical examiner?			eath (Check only one)	
of \	Phys this aldi	- T	1 XYes 2 No Picture 1 No Picture 27. Manner of Death			28d Describe how	ce 6 Nother (Specify) SCENE
on	After Ing	tion	1 □Natural 5 □ Pending 2 ☑ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tim- Injury 3/19/06 12:2	ry Work?	Drive	in motor vehicle
Division	r Attendi er death rector: A	Certification:	3 Suicide 6 Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (Stre City or Town,	et and Number or Rural Route Number.
۵	Hospitel or Attending 4 hours efter death. Funeral Director: After tely filled in by the fune		Continue 45 Continue Phys	High wa		Rd. F.	Softimore County MD
	To the Hospitel or Attend within 24 hours efter death To the Funeral Director: completely filled in by the t	edical	29a. Certifier 1 Certifying Phys (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of my knowledge, d er: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occurred the contract of the	ce, and due to the cau curred at the time, date	e and place, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License number	290	d. Date signed (Month, Day, Year)
	1		· Caroy Ha	elan nd	O.C.M.E.	M	ARCH 15, 2006
			30. Name and address of person who cou	npleted cause of death (Item 23a) (Ty an Mo		DATTEMODE	MADVI AND 21201
	St	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signature	III PENN SIKEET	DALITMOKE	, MARYLAND 21201
	Regist		MAD 1 7 2006	From A Co			

			For State Registrar	State of M	aryland		artment of I				giene	06	081	68
	B 46		Decedent's Name (First, Middle, Las	t)						2. Date of Dea Month		Year	3. Time of	Death
	Physicia /Medic			Margaret	Mary	Roth				March		2006	11:40	A ^M
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town,	or Location	of Death		4c. Cou	nty of Death	1	
			Rockville Nursin				Rockvi		24 Hrs	0.5-4(8:4		tgome		
	Funeral Director		5. Social Security Number 6. Se 1	ex □M 2∏XF	ge (In yrs. Ia 88	Yrs.	Months Days		Min.	8. Date of Birt (Month, Day October	, Year) 27, 191	7 Con	nplace (State of untry) necticu	-
7			Usual Residence of Decedent						ļ l	OCCOBCI	<i>-,</i> 1)1			
	nyland how		10a. State 10b. County			Town or Lo							10d. Inside Cit	
	89-18	cto	New York Westches	ster	N	New Ro	chelle						1 🗆 Yes	2 X No
	or 2	Directo	10e. Street and Number				10f. Zip Code	,			10g. Citizen		•	
	s 23s	erai	141 Verdun Avenue	12. Was Decedent	Ever in 11 9	13 1	1080 Was Decedent of		rigin? (Spe	cify Yes or No		ed Sta		
350	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28e-f show other treumstice event, the Medical Example must be multilast at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces: 1 Yes 2 X If Yes, Give Year or Dates:	No	If Yes, specify Cuban, Mexican, Puerto Rican, e 1 ☐ Yes 2 🎇 No Specify:					No- 14. Race - American Indian, Black, White, etc. Specify: White			
0500-c	2 hou		15. Decedent's Ed	ucation			ient's Usual Occu		st of working	10	16b. Kind o	f Business/I	ndustry	
7	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retire	ed)	st of Workin	<i>'</i> 9				
7	led will ygien her th	So	12		<u> </u>	Ho	memaker	10 Moth	or's Namo	(First, Middle,		Home		
yland	tal H	Be	17. Father's Name (First, Middle, Last)								Maiden Sun	ianie)		
Ĕ	d Med mark matic	70	John Gallagher 19a. Informant's Name/Relationship (7)	Vpe. Print)		19b. Mailir	ng Address (Stree			ynolds Route Numbe	er, City or To	wn, State, Z	ip Code)	
Mar	ith an 27 is treu		Jane Roth / Daugh				Lilly St				-			.7
ē,	f Hearlitem		20a. Method of Disposition		20b. Pla		sition (Name of natory or other pla	2001	D	ate	20c. Location			
Ē	Pages ent of nt: If i	Ιί	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)		Crematoriu		March 200		Bethe	sda, N	Marylan	d
Baltimore,	permit. Pages of begardment of harmontant: If ite any injury or of once.		21. Signature of Furral Service Licen	260	м01	.305 Rc	bert A. I West Mo	ess of Facili Umphre ntgomer	y Fune y Aver	ral Home nue, Rock	/Rockvi	lle, Ir Marylar	nc. nd 20850-	-2805
- Tr.	Ž'		23a. Part1. Enter the disease, or companies shock, or heart failure. List only	olications that cause	d the death.	. Do not ent	er the mode of dy	ing, such as	s cardiac o	r respiratory ar	rest,		Approximate Interval Bet	ween
	Physician		Immediate Cause (Final disease or condition		oticem	nia							Onset and I	Death
	/Medical		resulting in death)	Due to (or as										
	Examiner		Sequentially list conditions,	b			ementia							
yĹ	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):											
	and and II-tran	хап									-			
2/60	ate be executed obysicien and the burial-transit	caiE		d										
289	ificate g phy as the			. d.									.,,	
XOX	death certificate be executed e attending physicien and nd for use as the burral-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pregnan	CV			23d.	Date of deli		
	death	sicia	in the past 12 months? 1 ☐ Yes 2 🖾 No	4☐Pregnant a			Other (specify)					Month	Day ^	/ear
j	at the de by the a	hys	9 🗆 Unknown											
ecords, I	law requires that the es been signed by th 2 should be detache	þ	Part II. Other significant conditions o	ontributing to death	but not resu	Iting in the u	nderlying cause g	iven in Part	I.		Yes 2 N		the cause of do	
ပ္မ	law rees be	pie			<u></u>					24a. Was autor	osy	prior to c	topsy findings completion of c	available ause of
r	The Tate he	Completed									2 No	death?	2 🗆 No	
VII	rsicien: The law s certificate hes t firector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:				th a m		(Check only o				
0	Physi this o	၉	1 ☐ Yes 2 ☒ No 27. Manner of Death	Hospital: 1 ☐ Inpat		ER/Outpatie 28b. Time o	IL 3LI DOA			me 5 Residence Residence Residence			cify)	
c C	ding l h. After funer	E I	1 XNatural 5 ☐ Pending	28a. Date of Inj (Month, D	ay Year)	Injury	W	ork? □Yes 2□		Edd. Describe	now injury oo	ouriou		
Division	Attending Physicien: ar death. ector: After this certific by the funeral director,	ertification;	3 Suicide 6 Could not b	28e. Place of Ir			reet, factory, office			28f. Location (umber or Ru	ıral Route Num	ber,
2	P de la c	erti	4 Homicide	building, e	tc. (Specify	")				City or To	wn, State)			
	To the Hospitel or Attenwihin 24 hours after deat To the Funerel Director: completely filled in by the	Medical C		ysician: To the bes niner: On the basis and manner s	of examinat)
	To the To the somple	Me	29b. Signature and title of certifier				29c. Licer	nse number			29d. Date si	gned (Monti	h, Day, Year)	
			Nouns	V.J	oupl	1	D00	47330			Marcl	h 16,	2006	
	10		30. Name and address of person who Thomas V. Joseph,				Print)	ive, I	Rockv	ille, M	farylar	nd 208	352	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Resis	trar's Signat	ture	Leel B						· · · · · · · · · · · · · · · · · · ·	
*	Regist	rar	MAR 1 7	2006	eper.	A A	The state of the s							

			for State		f Marylan	d / Depa		t of H	ealth a	and M	•	giene	nna	08169
			Registrar 1. Decedent's Name (First, Middle, I	(ast)		00,	incan	01 1	Juan		2. Date of De	Reg. No	000	3. Time of Death
	Physicia	an									Month	Day	Year	
	/Medic	_	Morris Green R				4h City Tourn or Legation of Dogth				March	15	2006	8:48 p M
1	Examin	er	4a. Facility Name (If not institution, g				4b. City, Town, or Location of Death					4c. County of Death Carroll		
_			Carroll Hospi 5. Social Security Number 6	. Sex	7. Age (In yrs.	last hirthday)	Westminster If Under 1 Year ff Under 24 Hrs. 8. Date of Birth							place (State or Foreign
	Funeral Director		215-12-1141	.Sex 1∭2 M 2□ F	7. Age (iii yis. 84	Yrs.	Months		Hours	Min.	(Month, Da	1921	Cou	yland
	pu ,		Usuef Residence of Decedent 10a, State 10b, County		100 Cit	y, Town or Lo	nation						-	10d. Inside City Limits
	anyla shov	_		~ 7	100.01	•								1 ☐ Yes 2Ã No
	Sa-f	ctc	Maryland Carro	77		west	minst							
	death with the Maryland ms 23a or 28a-f show r must be notified at	Directo	10e. Street and Number				10f. Zip						n of What Cou	intry?
	ath v		1262 Weller				1	1158		1.0.10			S.A.	
	er de tams	Funerai	11. Marital Slatus	Armed F		.S. 13.	Was Deced ff Yes, spec	lent of Hi offy Cuba	ispanic Ori ın, Mexicar	gin? (Sp 1, Puerto	ecify Yes or No Rican, etc.)	- 14	. Race - Amer Black, White	
9	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 1 Yes Gi	2□No		1 ☐ Yes	2 XNO	Specify:			S	pecify: Whi	te
9500-61212	be filed within 72 hours after death with the Marylan tall Hygliene. all Hygliene. all Hygliene. all the transparent is a transparent to a confiled at event, the Medical Examiner must be notified at				ацьто	16a Daga	dent's Usua	I Casun	ation				of Business/li	
ភ្	n 72	Completed	15. Decedent's (Specify only highest	grade completed)		(Give	kind of woi	k done d	during mos	t of work	ing	IOD. KING	OI DUSINESS/II	nuustry
Z	within 72 ene. than na	E	Elementary/Secondary (0-12)	College (1-4or 5+)					ns Ot	fficer	Po	stal S	ervice
	e filed with al Hygiene other that		17. Father's Name (First, Middle, La	ist)					18. Mothe	er's Nam	e (First, Middle,	Maiden Si	umame)	
and		Be C	Calvin Edgar		on				Ar	nnie	Estelle	Robe	ertson	
5	should nd Men marke umatic	은	19a. Informant's Name/Relationship			19b Maili	na Address	(Street :			al Route Numb			in Code)
<u> </u>	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		Ruth Richardson				-				ninster	-		<i>p</i> 0000/
_	1 an Heali em 2 ther		20a. Method of Disposition	WIIC	20b. F	Place of Dispo					Date		tion - City or 1	own. State
Baltimore,	tment of trant: if ite		1 X Burial 2 ☐ Cremation 3		State Dr	emetery, crei	matory or o	ther plac em -	e) March	20.	2006			
	it. Partitudes ritant ritant njury		4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice				2. Name an						,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
a n	permit. Departmine importa any inju		21. Signature of Funeral Service Life	L Da		E	ckhar	dt F	hiners	d Ch	napel P.	Α.		
	40.244		of forces we			1	1605	Reis	terst	own.	Rd. Ow:	nes l	Mills,	Md. 21117 Approximate
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	nly one cause on	each line.	n. Do not en	ter the mod	e or dyln	g, such as	cardiac	or respiratory a	rest,		Interval Between Onset and Death
}	Physician		Immediate Cause (Finaf disease or condition	_a. A	rure	muo	cara	119	(0	à te	TETTA			2 hours
9	/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of:		_		1	15ea			
	Examine:		Sequentially list conditions,	b	Ordina (or as a conseq	ry	95	791	4	a	1589	\mathfrak{c}) year
i	p is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	uerfce of):			,				i i	
/	and trans	am	that initiated events resulting in death) Last	C	/									
/60,	be executed ician and burial-transit		1000ming in County Cutt	Due to	(or as a conseq	uence or):							1	
	e ys	dicai		d						-				
200	The law requires that the death certifica lie has been signed by the attending ph age 2 should be detached for use as th	by Physician/Med	IF FEMALE:											
X R R	ath ca ttend or us	an/	23b. Was decedent pregnant in the past 12 months?	1 Live	tcome of pregna birth 2 ☐ Fete	Ideath 3	⊒Ectopic pr					23	d. Date of deli- Month	very Day Year
- -	the a	Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Preg 9⊡Unkr	nant at time of d lown	leath 5L	Other (sp	ecify)						,
ĭ	w requires that the de been signed by the should be detached	P.	Part fl. Other significant condition	e contributing to	leath but out ros	ulting is the u	adoshina o		on in Bort I		23a Did 1	obacco use	contribute to	the cause of death?
Ś	res the iigne be d	Ď	AA		Natification in the s	alling in the d	inderlying c	ause givi	BILIILEAILI	•		Yes 2□		
Vital Records,	neen s	ted	Myelody	F1951	2							145 2	140 30110	Dadiy 4 Quinnoun
ပို	has b	pie	Kenal.	failus	9						24a. Was	OSV	prior to c	opsy findings available ompletion of cause of
		Completed									perfo	rmed?	death? 1 ☐ Yes	2 🗆 No
<u>=</u>	sician: certific irector.	Be (25. Was case referred to medical examiner?	1					26. Place	of Deat	h (Check only o	ne)		
>	Physic this ce al dire	၉	1 ☐ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatie	nt 3 🗆 DC	A Oth	er: 4□Nu	ursing Ho	ome 5 ☐ Resi	dence 6 (□Other (Spec	ify)
n of	ng Ph Iter th neral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date (Mor	of Injury th, Day Year)	28b. Time o	of 2	8c. Injun	y at k?		28d. Describe	how injury	occurred	
<u> </u>	uttendir death. ctor: Al y the fu	atic	2 ☐ Accident investiga	tion			М		Yes 2□	No				
Division	r Attending F er death. rector: After by the funera	Ħ	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 28e. Plac	e of Injury - At h	ome, farm, st	reet, factory	, office			28f. Location (City or To		Number or Ru	ral Route Number,
5	s aft ai Di	Certification:									ĺ			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 12 Certifying (Check only 2 Medical Ex	Physicien: To the leminer: On the l	e best of my kno	owledge, deat	h occurred	at the tin	ne, date ar	nd place,	and due to the	cause(s) a	nd manner as	stated.
	in 24 in 24 in 6 in 6	Medicai	one)	and mar	ner stated.	THOSE AND THE				xiii occui				
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	2 ,			290		e number			-	signed (Month	
			1 Em Atal	Kyms	Cardi.	ologia	54	0 (1	033	33°	88	3	16/06	
	10		30. Name and address of person w			n 23a) (Type,	Print)			n	7 4	1	· · · · · ·	er-mD 21157
_			Evan Sel	sky mi) ~	410	malco	1/m	Bri	ve .	FA (Nest	minst	er-mo 21157
	Sta		31. Date filed (Month, Day, Year)		Registrar's Signa	ature								
	Registi	rar	MAR 1 7 20	06	wa do	Mas								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year (AM **Physician** RELO SUSIE 135 MANCH 09 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis Randallstown Randallstown Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 21930960 Yrs. 95 June 30, Director 1910 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-1 ehow event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Baltimore Randallstown Directo 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? ò 9109 Liberty Road or iteme 23a 21133 USA Funerai Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify: black. "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk then Elementary/Secondary (0-12) College (1-4or 5+) 12 housekeeper item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Ulysses Bennett Mary D. Gross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk Connie Jackson/grand daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of H
Important: if ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of the neral Service ROLL 21. State Anatomy Board 655 W. Baltimore Street S. Wade, more Baltimore, MD 21201 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examine burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed SUVE the attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: USB 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ۵ 2 ☐ ER/Outpatient 3 ☐ DOA Director: After this in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier

State Registrar

31. Date filed (Month, Day, Year) MAR

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BENR

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760.

29c. License number

CHARLES	ision of Vital Becords. P.O. Box 68760
10,	rds PO
CLAND	al Reco
STRICK	of Vit
57	ision

		Please 1 1 - For State Registrar		/land / Dep	artme	le Ink. Ensure nt of Health and <i>te of Death</i>	-		e	0.01.17.1
Physic		Decedent's Name (First, Middle, Last Charles)	Strick			2. Date of I Month MARCH	Death Da	y Year	3. Time of Death 05:58Am
/Med Exam Funera	iner	5. Social Security Number 6. Se	HOSPITAL × 7. Age (II	n yrs. last birthday,	e	y, Town, or Location of De- BALTIMORE er 1 Year If Under 24 H Is Days Hours Mi	ath	40	. County of Dea	
Directo		212–58–7988		Yrs. Oc. City, Town or L		Days Hours Mi	5-1			Md. 10d. Inside City Limits
the Maryli r 28a-f eho	Director	Md. NA 10e. Street and Number		Balt	imor	Ce		10g. Ci	tizen of What C	Y∑Yes 2 □ No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any njury or other traumatic event, the Medical Exactle at mark to inclined at once.	by Funeral D	1022 Lenton Avent 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	r in U.S. 13.		21212 edent of Hispanic Origin? ecify Cuban, Mexican, Put 2X No Specify:	(Specify Yes or erto Rican, etc.)	No-	USA 14. Race - Am- Black, Whi Specify: E	erican Indian,
LI JOUC hin 72 hour e. In "natural Medical Es	Completed b	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	ıcation	16a. Dece (Give	edent's Us s kind of w DO NOT	ual Occupation work done during most of w use retired)	vorking	16b. K	ind of Business/Industry	
IVIGITY CALLA TO TO SOLUTION OF A LANGUAGE AND A LA	Ве Соп	12th grade 17. Father's Name (First, Middle, Last)	Edwar		pervi trick		ame (First, Midd	lle, Maider	Sumame)	ate Univ. Jackson
d 2 should the and Mer the and Mer traumatic traumatic	To	Charles 19a. Informant's Name/Relationship (7) Donald Faye Strice	vpe, Print)	19b. Mail	ing Addre	sland Annie ss (Street and Number or aton Avenue,	Rural Route Nun	-	or Town, State,	Zip Code)
Deficiency of personal participation of Heel mportant: if item 2 kmy njury or other pressore and personal perso		1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garden of Faith 3-20-06 Balt:								r Town, State
permit. Departm Importa		21. Signature of Funeral Service Licens	ware)		and Address of Facility F.H. East			ore, Mo orth Ave	
Pnysiciar /Medica Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	ilications that caused the ne cause on each line. a. SEPS IS Due to (or as a co	onsequence of):	iter the mo	ode of dying, such as card	ac or respiratory	arrest,		Approximate Interval Between Onset and Death / Welk
ficate be executed physicien and is the burial-transit	edicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C								
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the 1	by Physician/Medic	1 II we high 2 Fetal death 3 Fetanic groupency							23d. Date of de Month	elivery Day Year
w requires that I been signed by should be deta		Part II. Other significant conditions co	ntributing to death but n	ot resulting in the u	underlying	cause given in Part I.				o the cause of death? Probably 4 ⊠Unknown
The law ricete hes be	Completed						24a. W au pe 1 \(\text{Yes}	topsy rformed?	death?	utopsy findings available completion of cause of s 2 No
sician certif irector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☑ Inpatient	2 ER/Outpatie		Othor	eath (Check onl		2 🗆 🗆	
To the Hospital or Attending Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ation: To	27. Manner ol Death 1 A Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye			28c. Injury at Work? 1 Yes 2 No	Home 5 Re 28d. Describ			өспу)
tai or Atters after de rai Directo	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place ol Injury building, etc. (S	- At home, farm, st Specify)	reet, facto	ory, office		(Street ar Fown, State		iural Route Number,
he Hosp in 24 hou he Funei pletely fil	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of miner: On the basis of ex and manner stated	amination and/or in	th occurre nvestigation	od at the time, date and pla on, in my opinion, death od	ce, and due to ti curred at the tim	ne cause(s e, date an) and manner a d place, and du	s stated. e to the cause(s)
To t Withi To t	2	29b. Signature and title of certifier Manpuet	Mangal	MD	2	9c. License number P 19926		29d. Da	ite signed (Mon	th, Day, Year)
5		30. Name and address of person who c	ompleted cause of deati	h (Item 23a) (Type	Print)	P19926 MD 21229	Mac	700	o+ 11	noct
S Regis	tate trar	31 Date filed (Month, Day, Year)	006 32 Registrar's		1845	P	1-1041	PIC		an Just

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 3 5 haw 3:57PM **Physician** Ballaid 2006 /Medical Baltimore

Baltimore

Sinholace (State or 4b. City, Town, or Location of Death 4a. Facility Neme (If not institution, give street and number) Examiner Baltimore avenue Forest Age (In yrs. last birthday) Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth Security Number 6. Sex **Funeral** 1□M 2XF Days Hours Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location the Medical Examiner must be notified at 1 Yes 2 No Funeral Director timore 10f. Zip Code 10g. Citizen of What Country? crest 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 € No 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No 5 Baltimore, Maryland 21215-0036 Black Specify: Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. other Maiden Sumame) Mother's Name (First, Middle, permit. Pages 1 and 2 should be flit Department of Health and Mental Hy Important: if Item 27 is marked oth eny injury or other traumatic event 2002. 17. Fatheds Name (First, Middle, Last) comer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) laxwell Daughter the 3620 W. Fores
20b. Place of Disposition (Name of Batto. MD 21216 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation
4 Donation 5 Other (S 5 Other (Specify) 21 sign ture Funeral Service Randa 11 strung MO 2005 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 12 mentia 5489KS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Que to (or as a consequence of) physiclen at the burial-t Physician/Medicai as the the attending esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year signed by the atte 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one)

Division of Vital

completely filled in by the funeral director To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After

Certification:

State Registrar

1 ☐ Yes 2 ☐ No

Other:

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2000

4 Nursing Home 5 Residence 6 □Other (Specify)

28d. Describe how injury occurred

1 🗌 Inpatient

28a. Date of Injury (Month, Day Year)

5 Pending investigation

6 Could not be determined

2FINo

29b. Signature and title of certifier

1 🗌 Yes

27. Manner of Death

2 Accident

3 Suicide

29a, Certifier

4 | Homicide

Natural



2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			State of Maryland / D 1- State Amend #5 Per FH G862 12/27/06 J	epartment of be rtificate of	Health and Mental F Death	Hygiei Reg.	21116	08173	
	Physici /Medic		Decedent's Name (First, Middle, Last) EDITH PLUMLY SIMPSON		2. Date of Month MARCH		Day Year 2006	3. Time of Death	
	Examin		4a. Fecility Name (If not institution, give street and number)		or Location of Death		4c. County of Death		
1	Funeral Director		5. Social Security 10340 6. Sex 7. Age (In yrs. last birth 10 M 2 M F 84	day) If Under 1 Year Months Days	r If Under 24 Hrs. 8. Date of	Day Ye	irth (Say, Year) OHIO CARROLL 9. Birthplace (State or Foreign Country) OHIO		
90	D .		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location				10d. Inside City Limits	
	Aaryla f eho	ō	MARYLAND CARROLL WESTMIN					1 ☐ Yes 2 🖔 No	
	r 28e-	Director	10e. Street and Number	10f. Zip Code		10g.	Citizen of What Cou	untry?	
	th with	ai D	225 FROCK DR., APT. 101	2115			ITED STAT	ES	
20	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23a or 28e-f ehow any injury or other traumatic event, I'm Medical Exartmat must be notified at anotes.	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Ammed Forces? 1 ☒ Yes 2 □ No If Yes, Give Year or Dates: WW II	13. Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 ☒ No	Hispanic Origin? (Specify Yes or ban, Mexican, Puerto Rican, etc.) Specify:	No-	No- 14. Race - American Indian, Black, White, etc. Specify: WHITE		
3	2 hours		15 Decedent's Education 16a (Decedent's Usual Occu	upation	16b	b. Kind of Business/li		
7	ithin 7 18. "n	ompieted	Elementary/Secondary (0-12) College (1-4or 5+)		e during most of working ed)				
7	Hygier Hygier her th	O	17, Father's Name (First, Middle, Last)	ECRETARY	18. Mother's Name (First, Mid	idle Maii	OFFICE (WORK	
	d be fi	o Be	HOWARD DONALD PLUMLY		HELEN BING	gra, maid			
3	shoul nd Me	T ₀		Mailing Address (Stree	at and Number or Rural Route Nu	mber, Ci	ity or Town, State, Z	îp Code)	
Ž	and 2 alth a n 27 is er tra				ON AVE., SYKESV				
pairmore	Pages 1 (ment of He ent: if Iten ury or oth		1 ☐ Blurial 2 Incremation 3 ☐ Removal from State	Disposition (Name of crematory or other place of CREMATORY,	11111011 1, ,		Location - City or TONSVILLE	Town, State , MARYLAND	
Dall	permit. Departimport Import any inj		21. Signature of Funeral Service Licenses	421 CRAIN	UDDICK FUNERAL I HWY., S.E., GL	EN BI	URNIE, MD	21061 Approximate	
,00700	Physician /Medical Examiner be executed but and physician and street in the fortier of the forti	dical Examiner	23a. Part. Edjer the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or cause (Disease or injury that initiated events resulting in death) Last	uative F	ulmoxany Da			Interval Between Onset and Death	
O. DOX	The law requires that the death certific sie hes been signed by the ettending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mgnths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnand 5 □ Other (specify)		_	23d. Date of delivery Month Day Year		
'n	es that igned b	by Pi	Part II. Other significant conditions contributing to death but not resulting in	he underlying cause g				the cause of death?	
cords,	w require been si should t	eted				-		obably 4 Unknown	
Ilai nec		Completed			a p 1 □ Ye		prior to c death?	topsy findings available completion of cause of	
=	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Out	patient 3 DOA	26. Place of Death (Check or ther: 4 Nursing Home 5 F		a 6 □Other (Spec	n(v)	
5	ding Phys After this funeral di		27. Manner of Death 28a. Date of Injury 28b. Ti				injury occurred		
VISION	r Attendin er death. rsctor; Afi by the fur	Certification:	1 CMatural 5 Pending (Month, Day Year) In 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	M 1	yes 2 No 28f. Locatio	ion (Street and Number or Rural Route Number, or Town, State)			
2	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medicai Cer	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Exeminer: On the basis of examination and and manner stated.	death occurred at the for investigation, in my	time, date and place, and due to opinion, death occurred at the tir	the causine, date	uuse(s) and manner as stated.		
	Mithin 2 To the	Mec	29b. Signature and title of certifier	29c. Licer	nse number	29d.	Date signed (Month	ı, Day, Year)	
	r- s ⊢ ö		+ talat June un	000	1806	3	115/200	6	
	12		30. Name and address of person who completed cause of death (Item 23a) (INTRO) ATACK TURBS MID 100	ype, Print) Laberty	Rd Elder	sbu	3 MB	21784	
7	Sta Registr		31. Date filed (Month, Day, Year) 32 Registrar's Signature MAR 1 7 2006	Angel 8			<i>)</i> '		
1	negisti	Call	WINL T I TOOD TO THE TOP THE						

			For State Registrar	State of M	aryland / i		tment of H ficate of L			giene leg. No. 006	08175
			Decedent's Name (First, Middle, La	st)					2. Date of Dea	ith	3. Time of Death
	Physicia /Medic		Raymond J. Scl	hmitt					Month March	16, 2006	12:00 AM
	Examin		4a. Facility Name (If not institution, giv	re street and number)		4	b. Cily, Town, or	Location of Death	1	4c. County of Deat	th
		٠	Keswick Multicar					ore City			
	Funeral		5. Social Security Number 6. S	Gex 7.Ag 1.⊠M 2.□F	ge (In yrs. last bi		f Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day	r, Year) Co	thplace (State or Foreign buntry)
١.	Director		148-16-2445 Usual Residence of Decedent	44	79	115.			Sept.	3,1926 New	Jersey
	dand ow		10a. State 10b. County		10c. City, Tov	wn or Locat	tion		10d. Inside City Limits		
	Many If sh	ţō	New Jersey Middle	esex		Sou	th Plair	nfield			1X∑Yes 2 □ No
	n the	irec	10e. Street and Number				10f. Zip Code			10g. Citizen of What Co	ountry?
	23e c	alD	1205 Cherry Stree	et			07080)		United St	ates
	hours after death with the Maryland turel; or Items 23e or 28a-f show al Erar: it we must be multiled at	Funeral Director	11, Marital Status	12. Was Decedent Armed Forces?	?	13. Was	s Decedent of Hi es, specify Cubai	spanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
36	s afte	by Fu	1 Never Married 2 Married	1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:	No ταπαΤΤΤ	ł	Yes 2K No	Specify:			hite
21215-0036	hour turel		3 Widowed 4 □ Divorced			a. Decedent	it's Usual Occupa	tion		16b. Kind of Business/	
15	n "nel	Completed	(Specify only highest gra	ade completed)		(Give kin	d of work done d NOT use retired,	uring most of wor	rking		
212	d within giene. or then "	E O	Elementary/Secondary (0-12)	College (1-4or	5+)	Macl	hinist			Manufa	cturing
b	be filed within 72 hours after death with the Marylan ital Hygliene. Id other than "naturel", or liems 23e or 28e-1 show event, the Medical Exar, instruming the codified at	Be C	17. Father's Name (First, Middle, Last	")				18. Mother's Nan	ne (First, Middle,	Maiden Sumame)	
Vla I		10	Raymond Schmitt					Florence	ce O'Brie	en	
Maryland	2 sho and Is m		19a. Informant's Name/Relationship (r, City or Town, State, 2	
	is 1 and of Health item 27 other tr		Christine Schmitt	, Daughte					Baltimore Date	20c. Location - City or	
וסר	0 0		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □				on (Name of fory or other place				New
Baltimore,			 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Fuheral Service Lice 			-	lame and Addres	tery 3/2		. Plainfiel	
Ba	permit. Departr Importa any inji		1 BHM -	MO	1113			T _A IC		Home for F Lainfield,	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only								Approximate Interval Between
	Priysician	. 11	Immediate Cause (Final disease or condition	Squan	ans le	u a	arenon	a Ri	val		Onset and Death
	/Medical		resulting in death)				-40411		UWU		1000100101
				Due to (or as	a consequence		-4017		owe		www
	Examiner	L	(b		e of):			0000		777770
W	Examiner	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	a consequence	e of):			0000		www.oj
K	Examiner	xaminer	Sequentially list conditions, if any, leading to immediate	b		e of):			0000		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
760, 🗡	be executed ician and purial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	a consequence	e of):					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
68760,	be executed ician and purial-transit	edical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	a consequence	e of):					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
9	be executed ician and purial-transit	edical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	a consequence	e of): e of): e of):	ctopic pregnancy			23d. Date of del	ivery
Box 6	be executed ician and purial-transit	edical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 yes 2 No	b	a consequence a consequence of pregnancy 2 Fetal deat	e of): e of): e of): th 3□Ec				23d. Date of del Month	
P.O. Box 6	be executed ician and purial-transit	Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	b	a consequence a consequence of pregnancy 2 Fetal death	e of): e of): th 3 Ec 5 Of	ctopic pregnancy ther (specify)			Month	ivery Day Year
P.O. Box 6	be executed ician and purial-transit	by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the past 12 months?	b	a consequence a consequence of pregnancy 2 Fetal death titime of death	e of): e of): th 3 Ec 5 Ot	ctopic pregnancy ther (specify)		23e. Did to	Month	ivery Day Year
P.O. Box 6	be executed ician and purial-transit	by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the past 12 months?	b	a consequence a consequence of pregnancy 2 Fetal death titime of death	e of): e of): th 3 Ec 5 Ot	ctopic pregnancy ther (specify)		23e. Did to	Month baccouse contribute to	ivery Day Year o the cause of death?
P.O. Box 6	to law requires that the death certificate be executed that has been signed by the attending physician and the 2 should be detached for use as the burial-transit or the control of the co	by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the past 12 months?	b	a consequence a consequence of pregnancy 2 Fetal death titime of death	e of): e of): th 3 Ec 5 Ot	ctopic pregnancy ther (specify)		23e. Did to 1 24a. Was a autop	Month baccouse contribute to es 2 No 3 Pr an 24b. Were au sy prior to	ivery Day Year the cause of death? robably 4 Unknown utopsy findings available completion of cause of
Records, P.O. Box 6	The law requires that the death certificate be executed to the law requires that the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b	a consequence a consequence of pregnancy 2 Fetal death titime of death	e of): e of): th 3 Ec 5 Ot	ctopic pregnancy ther (specify)	in in Part I.	23e. Did to	Month bacco use contribute to es 2 No 3 Pr an 24b. Were an prior to death? 21 No 1 Yes	ivery Day Year the cause of death? robably 4 Unknown utopsy findings available completion of cause of
Vital Records, P.O. Box 6	The law requires that the death certificate be executed to the law requires that the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the past 12 months?	b	a consequence a consequence of pregnancy 2 Fetal death titime of death	e of): e of): th 3 Lec 5 Of	etopic pregnancy Ither (specify) erlying cause give	on in Part I.	23e. Did to 1 7 24a. Was a autop perfor 1 7 yes ath (Check only on	Month bacco use contribute to es 2 No 3 Pr an 24b. Were an prior to death? 21 No 1 Yes	ivery Day Year the cause of death? tobably 4 Unknown utopsy findings available completion of cause of
of Vital Records, P.O. Box 6	Physician: The law requires that the death certificate be executed to this certificate has been signed by the attending physician and train director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b	a consequence of a consequence of pregnancy 2 Fetal death time of death out not resulting	e of): e of): th 3 Lec 5 Of	etopic pregnancy Ither (specify) erlying cause give	on in Part I. 26. Place of Dea	23e. Did to 1	Month baccouse contribute to es 2 \(\text{No} \) 3 \(\text{Pr} \) an sy prior to death? 2 \(\text{No} \) 1 \(\text{Yes} \) re)	ivery Day Year the cause of death? tobably 4 Unknown utopsy findings available completion of cause of
of Vital Records, P.O. Box 6	ing Physician: The law requires that the death certificate be executed to the contilicate has been signed by the attending physician and the formeral director, page 2 should be detached for use as the burral-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b	a consequence of a consequence of pregnancy 2 Fetal death time of death out not resulting	e of): e of): th 3 □Ecc 5 □ Of in the unde	etopic pregnancy ither (specify) erlying cause give 3 □ DOA 28c. Injury Work	on in Part I. 26. Place of Dea	23e. Did to 1	Month bacco use contribute to es 2 \(\text{No} \) 3 \(\text{Pr} \) Prior to death? 2 \(\text{No} \) 1 \(\text{Yes} \) Yes ow injury occurred	ivery Day Year the cause of death? Tobably 4 Unknown utopsy findings available completion of cause of 2 No
of Vital Records, P.O. Box 6	Attending Physician: The law requires that the death certificate be executed to death. Interpr. After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit of the funeral director.	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b	a consequence a consequence a of pregnancy 2	e of): e of): th 3 □Ecc 5 □ Of in the unde Outpatient . Time of Injury	etopic pregnancy ither (specify) erlying cause give 3 DOA 28c. Injury Work M 1 N	26. Place of Dea	23e. Did to 1	Month bacco use contribute to es 2 No 3 Pr an yellow death? 24b. Were at prior to death? 25 No 1 Yes ence 6 Other (Specow injury occurred	ivery Day Year the cause of death? Tobably 4 Unknown utopsy findings available completion of cause of 2 No
Vital Records, P.O. Box 6	Attending Physician: The law requires that the death certificate be executed to death. Interpr. After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit of the funeral director.	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b	e a consequence e of pregnancy 2 Fetal death to time of death out not resulting ent 2 ER/O ury 28b. jury - At home, fite. (Specify)	e of): e of): th 3 Ecc 5 Oi in the under Dutpatient . Time of Injury farm, street	atopic pregnancy other (specify) erlying cause give 3 DOA 28c. Injury Work M 1 N	26. Place of Dea	23e. Did to 1 4 24a. Was a autop perfor 1 Yes ath (Check only or 10 Yes) 28d. Describe h 28f. Location (S City or Tow	Month baccouse contribute to es 2 No 3 Pr an year year year year year year year year	ivery Day Year the cause of death? tobably 4 Unknown utopsy findings available completion of cause of 2 No cify)
of Vital Records, P.O. Box 6	Attending Physician: The law requires that the death certificate be executed to death. Interpr. After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit of the funeral director.	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the past 12 months? 1 Yes 2 No 9 Unknown 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manual of Death 1 Natural 5 Pending investigation of the pending investigat	b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown contributing to death b Contributing to de	a consequence a consequence a of pregnancy 2 Fetal death time of death but not resulting ent 2 FR/0 ury 2 PR/0 ury 2 PR/0 ury 2 Sb.	e of): e of): th 3 □Ecc 5 □ Of in the under Dutpatient Time of Injury farm, street,	atopic pregnancy ither (specify)	26. Place of Dea 26. Place of Dea 17. 4 Hoursing Hat 27. (es 2 \(\subseteq \text{No} \)	23e. Did to 1 24a. Was a autop perfor 1 Yes ath (Check only or 1 Resid 28d. Describe h	Month bacco use contribute to es 2 No 3 Pr an yellow death? 24b. Were at prior to death? 25 No 1 Yes ence 6 Other (Specow injury occurred	ivery Day Year to the cause of death? tobably 4 Unknown utopsy findings available completion of cause of 2 No cify) ural Route Number,
of Vital Records, P.O. Box 6	Attending Physician: The law requires that the death certificate be executed to death. Interpr. After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit of the funeral director.	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as c. Due to (or as d. Due to (or as d. Pregnant a gold Unknown contributing to death by Hospital: 1 Inpation 28a. Date of Injuicing, elements of the building, elements of the basi	a consequence a consequence a of pregnancy 2 Fetal death time of death but not resulting ent 2 FR/0 ury 2 PR/0 ury 2 PR/0 ury 2 Sb.	e of): e of): th 3 □Ecc 5 □ Of in the under Dutpatient Time of Injury farm, street,	atopic pregnancy ither (specify)	26. Place of Dea 26. Place of Dea 37: 4 Urrsing Hat 27: (es 2 \subseteq No	23e. Did to 1 24a. Was a autop perfor 1 Yes ath (Check only or 1 Resid 28d. Describe has been been been been been been been bee	Month baccouse contribute to es 2 No 3 Pr an 24b. Were at prior to death? 1 Yes ence 6 Other (Specow injury occurred cause(s) and manner as date and place, and due	ivery Day Year the cause of death? robably 4 □Unknown utopsy findings available completion of cause of 2 □ No cify) ural Route Number, s stated. to the cause(s)
of Vital Records, P.O. Box 6	Attending Physician: The law requires that the death certificate be executed to relath. r death. ector: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit by the tuneral director.	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as c. Due to (or as d. Due to (or as d. Pregnant a gold Unknown contributing to death by Hospital: 1 Inpation 28a. Date of Injuicing, elements of the building, elements of the basi	a consequence a consequence a consequence a of pregnancy 2	e of): e of): th 3 □Ecc 5 □ Of in the under Dutpatient Time of Injury farm, street,	atopic pregnancy ther (specify) arrying cause give 3 DOA 28c. Injury Work M 1 N t, factory, office ccurred at the tim stigation, in my op	26. Place of Dea 26. Place of Dea 37: 4 Urrsing Hat 27: (es 2 \subseteq No	23e. Did to 1 24a. Was a autop perfor 1 Yes ath (Check only or 1 Resid 28d. Describe has been been been been been been been bee	Month baccouse contribute to es 2 No 3 Pr an 24b. Were at prior to death? 1 Yes ence 6 Other (Specow injury occurred cause(s) and manner as date and place, and due	ivery Day Year the cause of death? robably 4 □Unknown utopsy findings available completion of cause of 2 □ No cify) ural Route Number, s stated. to the cause(s)
of Vital Records, P.O. Box 6	Attending Physician: The law requires that the death certificate be executed to death. Interpr. After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit of the funeral director.	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as c. Due to (or as d. Due to (or as d. Pregnant a gold Unknown contributing to death by Label 28a. Date of Injute (Month, Date) 28a. Place of Injute (Month, Date) by sician: To the best miner: On the basis of and manner st	e a consequence a consequence a consequence a of pregnancy 2 Fetal death at time of death but not resulting ent 2 ER/O ury 1/ Year) cof my knowledg of examination a lated.	e of): e of): th 3 □Ecc 5 □ Oi in the under Dutpatient . Time of Injury farm, street, ge, death ocand/or inves	atopic pregnancy other (specify)	26. Place of Dea 26. Place of Dea 37: 4 Urrsing Hat 27: (es 2 \subseteq No	23e. Did to 1 24a. Was a autop perfor 1 Yes ath (Check only or 1 Resid 28d. Describe has been been been been been been been bee	Month baccouse contribute to es 2 No 3 Pr an 24b. Were at prior to death? 1 Yes ence 6 Other (Specow injury occurred cause(s) and manner as date and place, and due	ivery Day Year the cause of death? robably 4 □Unknown utopsy findings available completion of cause of 2 □ No cify) ural Route Number, s stated. to the cause(s)
of Vital Records, P.O. Box 6	Attending Physician: The law requires that the death certificate be executed to death. Interpr. After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit of the funeral director.	Medical Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b	e a consequence a consequence a consequence a of pregnancy 2 Fetal death at time of death but not resulting ent 2 ER/O ury 1/ Year) cof my knowledg of examination a lated.	e of): e of): th 3 □Ecc 5 □ Of finite under Dutpatient Time of Injury farm, street, ge, death ocand/or inves	atopic pregnancy ther (specify) arrying cause give the state of the s	26. Place of Dea 26. Place of Dea 37: 4 Urrsing Hat 27: (es 2 \subseteq No	23e. Did to 1 24a. Was a autop perfor 1 Yes ath (Check only or 1 Resid 28d. Describe has been been been been been been been bee	Month baccouse contribute to es 2 No 3 Pr an prior to death? 24b. Were an prior to death? 22 No 1 Yes ence 6 Other (Specow injury occurred creat and Number or Rules cause(s) and manner as date and place, and due	ivery Day Year the cause of death? robably 4 □Unknown utopsy findings available completion of cause of 2 □ No cify) ural Route Number, s stated. to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department 1- State of Maryland / Department 1- State of Maryland / Department (85.3 to 1)
Registrar Verbal Certificate of Health and Mental Hygiene **03/1-7/06dhb** of Death Reພາຄ Reg. No. 1. Decedent's Name (First, Middle, Last) Philip Daniel Spampinato 2. Date of Death 3. Time of Death ^{Day}2006 **Physician** Month Spampinato March 6:17p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Med. Center Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb 21 1951 Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 219-60-7048 55 Director Mď Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show in than "naturel", or items 23a or 28a-f ehov The Medical Examinar must be notified at Md Carroll Marriottsville 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7344 Brangles Road 21104 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. e filed within 72 hours after if Hygiene. other than "nature!, or Ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 Yes 2 No δ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) excavation contractor excavating 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: if Item 27 is marked oth any lighty or other traumatic event SIRS. 17. Father's Name (First, Middle, Last) Be Philip J. Spampinato Kathryn Landis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7344 Brangles Rd., Marriottsville, Md 21104 Pam Spampinato (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lake View Memorial 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 3-11-06 Sykesville, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel taist P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** subarachnoid hemorrhage with uncal herniation /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 ☐ Yes 1 Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 😾 No 2 ER/Outpatient 3 DOA this Director: After th 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License numbe**P19699** March 7, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ali Ekbatani MD 8541 Gradien Dr., Nottingham, Md 21236 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAR 1 7 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Morgan, A, Sm. 4h 2:00 PM 2006 March 10 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5. Social Security Number 6. Sex 7. Age (In y 13/210 Jung 8. Date of Birth (Month, Day, Year) Feb 11, 1932 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1₩ 2□F Hours 215-26-3733 74 Yrs MD Usual Residence of Decedent 10a. State 10h Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 6007 C Heritage Hill Dr 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 № Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Contractor Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Leroy Smith Eva Carr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Nancy Lynn Smith Wife 6007 C Heritage Hill Dr, Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XX remation 3 Removal from State Bayview Crematory 3-13-06 4 Donation 5 Other (Specify) Baltimore, MD Funeral Service Log 7 Name and Address of Facility p. A. Burnie, MD 426 Crain Hwy Sw, Glen Burnie, MD Enter the disease, or or heart failure. List omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, my one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Chron: c Obstuctive Palmonas fige ase 7 104 PWS Due to (or as a consequence of) S quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ves 2□No 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 → No 1□ Yes 2 No 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Department 2 ER/Outpatient 3□ DOA 28d. Describe how injury occurred

Physician /Medical Examiner The law requires that the death certificate be executed burial-transit P.O. Box 68760, use as the attending for use as

Physician

/Medical

Examiner

MD

Funeral

Director

other than "natural", or items 23s or 28s-f ehovent, the Medical Examinar must be notified at

of Health and Mental Hygie litem 27 is marked other t r other treumatic event, II

Department of Himportant: If its eny injury or of once.

Baltimore, Maryland 21215-0036

Funera

þ

Examine Physician/Medical been signed by the should be detached Completed by certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. Medicai Certification: To Be

Records,

Division of Vital

To the Hospital or Attending Physician:

23b. Was decedent pregnant in the past 12 months? 9 Unknown

25. Was case referred to medical examiner? 1 Yes 20€No

3 🗌 Suicide

29a. Certifier

4 ☐ Homicide

27 Manner of Death Natural 2 Accident

5 Pending investigation 6 ☐ Could not be 28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 Tes 2 No

llersville md

28f. Location (Street and Number or Rural Route Number, City or Town, State) **D'Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

29d. Date signed (Month, Day, Year) March 10, 2006

use of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature 7 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UUb Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Harold R. Scott, Sr. 2006 9:107 4 Physician March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MITHER Mary 1 , 4 Boltimura Washington If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1₩ 2□F Months 343-16-0910 82 Yrs. Director 6/13/1923 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: if Item 27 is marked other than "natural", or Items 23s or 28s-f show ury or other traumatic event, the Medical Exeminar must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County MD 1 ☐ Yes 2 ₩ No Anne Arundel Pasadena **Funeral Director** 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8336 Woodland Road 21122 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status If Yes, specify Cuban, Mexical ITYes, Specify Cuban, ITYES, Specify Cuban, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify. white Completed by 3 X Midowed 4 ☐ Divorced WWII 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LOngshoreman Shipping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Harry Scott Unk. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carol A. Singer / Daughter 8336 Woodland Road, Pasadena MD 21122 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Cedar Hill Cemetery 1 DBurial 2 □ Cremation 3 □ Removal from State March 18, 2006 Baltimore MD permit. Page Depertment of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) charles L. Stevens Funeral Home, Inc. 21. Significant Service Licensee Victor P. Doda Jr. 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, isaum g to immorphis cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a Examiner anding physicien and use as the burial-transit Due to (or as a cons u Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical ed by the ettending I detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Cher (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was aп certificate has autopsy 1 Yes 25 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funers! Director: After this certifice completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death | Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending 1- Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) 1

State Registrar

DHMH 17 Rev 1/2001

MAR 1 7 2006

32. Registrar's Signature

) What Downing on

ORIGINAL

5 2	Decedent's Name (First, Middle, Later Company) a. Facility Name (If not institution, give 6024 Amberwood R. Social Security Number 6. S	E. Sm	rith			2. Date of Dea		3. Time of Death
5 2	6024 Amberwood R	e street and number)				March	8, Day 2006 Year	8:44 A M
100		1 // 1/	11 T T T T T T T T T T T T T T T T T T		or Location of Death		4c. County of De	eath
1		ex 7. Age	(In yrs. last birthda	Baltimo y) If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth	9. E	Birthplace (State or Foreign
1	125-94-0532 1 Usual Residence of Decedent	MM 2□F L	+5 Yrs.	Months Days	Hours Min.	NOV. 27	1960 V	Tirginia
	Oa. State 10b. County	A	10c. City, Town or	Location				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
1	Oe. Street and Number	Λ .	Ball	10f. Zip Code	<i></i>	1	log. Citizen of What	
	6024 Ambe	Prwood	Rd. #B	4 216	206	agaifu Vac ar Na	US	A merican Indian,
	1. Marital Status 1 Never Married 2 Married	Armed Forces? 1 Yes 2 N If Yes, Give	lo	If Yes, specify Cul	Hispanic Origin? (St ban, Mexican, Puerto Specify:	Rican, etc.)	Black, W	
2	3 Widowed 4 Divorced 15. Decedent's E	Year or Dates:		edent's Usual Occu			Specify: 16b. Kind of Busine	ss/Industry
_	(Specify only highest gra Elementary/Şecondary (0-12)	ide completed)	(Giv	ve kind of work done . DO NOT use retire	e during most of worked)	king		,.
	7. Father's Name (First, Middle, Last,		- C	OOK	18. Mother's Nam	ne (First, Middle,		use of Pancake
	Clarence	Smith	Jr.		Haze	1 Lou	ise N	lorgan
	19a. Informant's Name/Relationship (Type, Print) LSIS	ter) 19b. Ma 49 1	iling Address (Stree	et and Number or Ru	1	R. City or Town, State	La GONDIA
2		Pomoval from State	20b. Place of Dis	position (Name of rematory or other pl	(ace) 0/10	Date	20c. Location - City	or Town, State
1	4 □Donation 5 □ Other (Specif	ý)	Trinite		ery	12006	Dundal	K, Nd.
	10 Seph Lices	Liku	N	loseph (I. Russ	Funera	Ind. Zizi	P.A.
4	•	plications that caused one cause on each lin	the death. Do not e	enter the mode of dy	ring, such as cardiac	or respiratory are	rest,	Approximate Interval Between Onset and Death
- 1	disease or condition	· · · · · · · · · · · · · · · · · · ·	*				-	
	Sequentially list conditions,	b						
	cause. Enter Underlying Cause (Disease or injury	Due to [or as a	a consequence or:					
i '	resulting in death) Last	Due to (or as a	a consequence of):					
_		d						
	23b. Was decedent pregnant	1☐Live birth	2 Fetal death		су		23d. Date of Month	delivery Day Year
2	1 Yes 2 No	4∐Pregnant at 9∐ Unknown	time of death	5 ☐ Other (specify)				
		contributing to death bu	ut not re <i>s</i> ulting in the	underlying cause g	given in Part I.			
-	ocame use				··			Probably 4 Cinknown autopsy findings available
-						autop perfor	sy prior med? death	to completion of cause of
: נ	examiner?	Hospital:	-5-5-6	-7				at scene
	27. Manner of Death	1 🗀 inpatie		IBRIT 3 DOA				pecify) a b b c c c c
2	2 ☐ Accident investigation 3 ☐ Suicide 6 ☒ Could not be	n Fnd 3/8/20	006 Fnd 8:0	O AM 1	Yes 2 XNo	unk	Street and Number of	r Rural Route Number
	4 Homicide	building, etc	c. (Specify) home	загова, тастогу, отно	Ð			nberwood Rd.
	(Check only 2 Medical Exa	miner: On the basis of	examination and/or					
35								* '
	Hatricia (honica	- Yollet	0 0	.C.M.E.		March 9, 2	2006
	William S. A.	completed earese of d	eath (Item 23a) (Typ	oe, Print) 1 Penn St	reet, Bal	timore,	Maryland	21201
		19a. Informant's Name/Relationship (19a. Informant's Name/Relationship (19b. Let Need 19b. 19b. 19b. 19b. 19b. 19b. 19b. 19b.	19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 20a. Method of Disposition 1	19a. Informant's Name/Relationship (Type, Print) 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signification of Funeral Service Licensee 23a. Part / Enter the dylease, or complications that beused the death. Do not ensure the shock of heart falfure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, lamy last ling to manufact acuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the Cocaine USe 25c. Was case referred to medical examiner? 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 M Could not be determined investigation and manner stated. 28e. Place of Injury - At home, farm, building, etc. (Specify) Found and manner stated.	17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street Ms. Learning Address (Street M	19a. Informant's Name (Pists, Middle, Last) 19b. Mailing Address (Street and Number or Rum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rum 19b. Mailing Address (Street) 19b. Live birth 19b. Mailing Address (Street) 19b. Mailing Address (Street) 19b. Live birth 19b. Mailing Address (Street) 19b. Live birth 19b. Mailing Address (Street) 19b. Live birth 19b. Live birth 19b. Mailing Address (Street) 19b. Live birth 19b. Mailing Address (Street) 19b. Live birth 19b. Live birth 19b. Mailing Address (Street) 19b. Live birth 19b. Live bir	17. Father's Name (First, Middle, Last) 19b. Mailling Address (Street and Number or Rural Route Number 19b. Mailling Address (Street and Number or Rural Route Number 19b. Mailling Address (Street and Number or Rural Route Number 19b. Mailling Address (Street and Number or Rural Route Number 19b. Mailling Address (Street and Number or Rural Route Number 19b. Mailling Address (Street and Number or Rural Route Number 19b. Mailling Address (Street and Number or Rural Route Number 19b. Mailling Address (Street and Number or Rural Route Number or Rural Route Number 19b. Mailling Address (Street and Number or Rural Route Number or Rural Route Number 19b. Mailling Address (Street and Number or Rural Route Number or Rural Rou	10. Montan's Name (Pinst, Middle). Last) 11. Montan's Name (Pinst, Middle). Last) 12. Informati's Name (Pinst, Middle). Last) 12. Informati's Name (Pinst, Middle). Last) 12. Informati's Name (Pinst, Middle). Last 12. Informati's Name (Pinst, Middle). Last 12. Seyminut of Deposition (Pinst of Depo

			For State	State of	Maryland / [epartm <i>Certific</i>			d Mental Hy	ygiene Reg. No.	06	08180
			Registrar 1. Decedent's Name (First, Middle,	Last)					2. Date of D	eath		3. Time of Death
	Physici		Matthew A. Snyo	Per					Month	Day	200/a	3:04 PM
	/Medic Examir		4a. Facility Name (If not institution,		ber)	4b. C	ity, Town, or	r Location of D	Death	4c. Coun	ty of Death	1 9 9
	Exami		Franklin Sau	avo. Has	sortal	1	2050	dale		bo	Iltin	1000
	Funeral		5. Social Security Number		. Age (In yrs. last bir	thday) If Ur Mont	nder 1 Year	If Under 24 Hours	Hrs. 8. Date of B Min. (Month, D 06/06)	irth	9. Birthi	place (State or Foreign
	Director		217-09-9246	1 ∑ M 2□F	89	Yrs.	liis Days	1 Todis	06/06,	/1916		yland
	D .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	or Location						10d. Inside City Limits
	ehow	5										1 ☐ Yes 2 ☑ No
	Z8a-f	ect	MD Balt:	ımore	Perry		Zip Code			10g. Citizen o	f What Cou	
	ath with the Maryla r 23a or 28a-f ehov	٥		na Dona		101.	21128	2		U.S.A		indy.
	death with the Maryland rms 23a or 28a-f ehow frount by multing at	Funeral Director	4622 East Jopp		lent Ever in U.S.	13. Was De			? (Specify Yes or Note of Rican, etc.)		ace - Ameri	can Indian,
3,0	r Her d	표	1 ☐ Never Married 2 ☐ Marrie	Armed Ford	es?				uerto Rican, etc.)	8	lack, White,	etc.
28	ei', or	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dat	es: WW II	1 □ Ye	s 2 X No	Specify:		Spec	ify: Wh:	ite
20-5	within 72 hours after ene. then "naturel", or ite he Medical Examina	Completed	15. Decedent's (Specify only highest		16a.	Decedent's U	Jsual Occup	ation during most of	working	16b. Kind of	Business/In	dustry
77	ithin 19	npie	Elementary/Secondary (0-12)	College (1-4		life. DO NO	T use retired	d) -	•			
21	D 0 2	Š	8			CaRPEN	TRY/Fa		None (Cina Middle			d Farming
7	a la b ≽	Be	17. Father's Name (First, Middle, L.	ast)					Name (First, Middl			
Z Z	should ind Men marke umatic	မ	Jospeh Peter St 19a. Informant's Name/Relationshi		106	Mailine Add	(Steam	Mary	Catherin	ne Light	ner	- Codel
Mag	d 2 sho h and 7 ie m treum	1 3										
e,	s 1 and 2 should f Health and Mer item 27 ie marke other treumatic		Emma Barzyk (1 20a. Method of Disposition	neice	20b. Place of	Disposition	(Name of	-	d - Perry Date	20c. Location	Mary I n - City or T	and 21128 own, State
Saltimor	00		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		tate	ry, crematory			/17/2006	D-11-4	>1	
量			21. Signature of Funeral Service L		Highv	Lew Mer	n. Gan e and Addre	ss of Facility	/17/2006	ralist	on, M	aryland Home, P.A.
Ba	permit. Departr Imports eny inju		1 C 91 0	Parada					l - Kings			
			23a. Part1. Enter the disease, or o	omplications that car	used the death. Do						RAL Y LO	Approximate
	Physician		shock, or heart failure. List o	niy one cause on ear	1 12 ac o	icat	NI.	Deduce	SS SII	advance	0	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. HOUL	r as a consequence	of):	00	DPIL	32 20	ndrow	10	
	Examiner			Pro	umomi	a						
7		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	U	r as a consequence	· · · · · · · · · · · · · · · · · · ·						
V	ocuted nd transi	Examiner	that initiated events	с								
,00	e exe sian a urial-	E	resulting in death) Last	Due to (o	r as a consequence	of):						
8760	cate b	dical		d							-	
9 ×	ding p	Me	IF FEMALE:	23c If was outco	ome of pregnancy					2016	N. 1	
Вох	attene for us	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bir	th 2 ☐ Fetal death nt at time of death	3 □Ectop 5 □ Other	ic pregnancy	/			Date of deliv Month	ery Day Year
P.O.	the de	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknov		3 🗆 🔾 (1) 0	(specify) _					
مَ	that ned by deta	Y P	Part II. Other significant condition	s contributing to dea	ath but not resulting i	the underlyi	ng cause giv	en in Part I.	23e. Did	tobacco use co	ntribute to t	the cause of death?
rds	tuires n sigr	Q P							1]Yes 2□No	3 🗌 Pro	bably 4 Unknown
3	s bee	Completed by Physician/Me							24a. Wa	is an 24t	o. Were auto	opsy findings available ompletion of cause of
Re	The is	E							— aut per 1□Yes	formed?	death?	ompletion of cause of 2 No
ital	en: tufica tor. p	BeC	25. Was case referred to medical					26. Place of	Death Check only		1	2010
>	ysicl lis ce direc	TO E	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Mn	patient 2 ☐ ER/Oι	tpatient 3	DOA Oth	ier: 4 ☐ Nursi	ng Home 5 □ Re	sidence 6 🗆 C	ther (Speci	<i>fy</i>)
0 4	ng Pt Iter th neral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of (Month	Injury 28b.	Time of njury	28c. Injur Wor	y at	28d. Describe	e how injury occ	urred	
9.0	endii eath. or: A	catio	2 Accident investiga	ation		М		Yes 2 □ No				
Division of Vital Records,	ter diffect	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ned 28e. Place of building	of Injury - At home, fa g, etc. (Specify)	irm, street, fa	ctory, office		28f. Location City or T	(Street and Nur own, State)	nber or Rur	al Route Number,
	urs al		20.0.4									
	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burist-transit	ledicai	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the b xaminer: On the bas and manne	sis of examination an	e, death occu id/or investiga	rred at the tir ation, in my o	me, date and p ppinion, death	occurred at the time	e cause(s) and e, date and plac	manner as s e, and due t	of the cause(s)
	To the To the Comp	Ž	29b. Signature and title of ceptifier				29c. Licens	e number		29d. Date sign		
			Smes	21			Res	0000	20	05-	14-	2006
i	XI		30. Name and addressed person w	no completed cause	of death (Item 23a)	(Type, Print)	4	10	2) 11	. 1 . 1	79 51537.
()		Ur Damant	a Unic	gistrar's Signature	DHO	MKI	U 50	Wive !	Datim	1,90	40 21231
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 1 7 20	106	gistrar's Signature	booker						

		1- State Amend Item 23a per	Maryland / Dep Dr., 6853, 037	artment of Health and I // Oodhb Tificate of Death	Mental Hygi	ene s N2 006 08 8			
Physic /Med		Decedent's Name (First, Middle, Last) Adolf Salinger			2. Date of Death Month March	7 2006 3. Time of Death 12:25P _M			
Exami		4a. Facility Name (If not institution, give street and num Sinai Hospital		4b. City, Town, or Location of Dea Baltimore		4c. County of Death			
Funera Director		5. Social Security Number 213-28-9278 6. Sex 12 M 2 F 7	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		(Year) 9. Birthplace (State or Foreign Country) Germany			
Maryland a-f show	tor	10a. State 10b. County MD	10c. City, Town or Lo Balti	more Co.		10d. Inside City Limits 1 □ Yes 2X No			
th with the 23a or 28	ai Director	10e. Street and Number 6605 Windsor Mill Rd.		10f. Zip Code 21163	10	g. Citizen of What Country?			
ine, Maryland Z1Z15-UU36 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23s or 28s-f show other treumstic event, the Madical Examinar must be natified at	by Funeral	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced 12. Was Decedamed For 1 Yes, 2 If Yes, 3 Yes Year or Date 1	ces? 2 <mark>M</mark> No	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puel 1 ☐ Yes XXIII Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			
Maryland 21215-UU36 nd 2 should be filed within 72 hours aft lith and Mental Hygiene. 27 is marked other than "natural", or riteumatic event, the Madical Exern	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th	(Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired) Realtor	orking	6b. Kind of Business/Industry Residental			
aryland Z should be filed and Mental Hygis s marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) Unk.			ime (First, Middle, M				
B, Maryl t and 2 shoul lealth and Me om 27 is mark ther treumati		19a. Informant's Name/Relationship (Type, Print) Geraldine Morton		ng Address (Street and Number or A Frederick Ave					
Baltimore, permit. Pages 1 at Department of Hea Important: If item eny injury or othe		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from S 4 □ Donation 5 □ Other (Specify)	Woodlaw	matory or other place) on Cemetery 3-1	13-06 W	oc. Location - City or Town, State			
Desmit. Departr Imports eny Inject.		21. Signature of Funeral Service Licensee	re. Balto	avis,Jr. FH D.MD 21231					
death certificate be executed death certificate be executed death certificate be executed e ettending physician and dor use as the burial-transit		Sequentially list conditions, if any, leading to immediate raus. First the original Cause (Disease or Injury that initiated events c.	ysphasia or as a consequence of): VA or as a consequence of):			Interval Between Onset and Death			
death certifi e ettending	Physician/Mec	in the past 12 months?	int at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year			
w requires that the been signed by the should be detached	5	Part II. Other significant conditions contributing to dea	ath but not resulting in the u	inderlying cause given in Part I.		acco use contribute to the cause of death? s 2 □ No 3 □ Probably 4 ☑dinknown			
The law ate hes b	Completed				24a. Was an autopsy perform 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death? 1 \(\text{Yes} \) 2 \(\text{No} \) No			
ding Physician: Th h. After this certificate funeral director, pag	tion: To Be	27. Manner of Death 1 Natural 5 Pending 28a. Date of (Month)	patient 2 ER/Outpatier I Injury Day Year) 28b. Time o Injury	nt 3 DOA Other: 4 Nursing	Home 5 Resider 28d. Describe how	nce 6			
or Atten after deat Director: in by the	Certification:	2 Accident 3 Suicide 4 Homicide 2 Be. Place of Injury : At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Factory, office building, etc.)							
Hoy Hoy Fur Fur	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the to and manner on the bar and manner of the bar and manner on the bar and manner on the bar and manner on the bar and manner on the bar and manner on the bar and manner on the bar and manner on the bar and manner on the bar and manner on the bar and manner of the bar and manner on the bar and manner on the bar and manner of the bar and manner of the bar	sis of examination and/or in	h occurred at the time, date and plac evestigation, in my opinion, death occ	e, and due to the car surred at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)			
To the within 2 To the complex	W	29b. Signature and title of certifier > Name L. Balti		29c. License number D0058676		d. Date signed (Month, Day, Year)			
		30. Name and address of person who completed cause Karron L. Babittum, 12, 25	main street,	Print)		40 21136			
Si Regis	tate trar	31. Date filed (Month, Day, Year) 32. Re	gistrar's Signature						

		4	For State Registrar	State of Maryla			nt of H			giene () ()	6 08	3182
3	1 7 m m		1. Decedent's Name (First, Middle, Las	0	1.				2. Date of Dea	ath	Year 3. 1	Time of Death
	Physicia /Medic		Jackie Ly	nn Smit	n				March			:05AM
	Examin	er	4a, Facility Name (If not institution, dive	01 00	inov	4b. City	-	Location of De Himor	e	4c. County o	Death A	
**	Funeral Director		210 17 17	X 7. Age (In y	rs. last birthday)	Months Months	Days	Hours M		v. Year)	9. Birthplace (Country)	State or Foreign
	and wo	1	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation					10d. In	side City Limits
	Sa-f sho	Director	MD N/A		Bal			ك			1)	Yes 2 □ No
	th with the 23a or 2	al Dir	2711 Pelham	Avenue		10f. Zi	p Code	213	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	10g. Citizen of W	hat Country?	
215-0036	permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel" or Items 23a or 28a-f show striping or other traumatic event, Ire Medical Examinal Reprofiled at angles.	by Funeral	11. Marital Status 1 ☑Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Dece If Yes, spe 1 ☐ Yes	ecify Cubai	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)		- American Inc. White, etc.	
5-0	72 ho	eted	15. Decedent's Ed (Specify only highest grad		(Give	kind of w	ual Occupa ork done d	uring most of v	vorkina	16b. Kind of Bus	siness/Industry	
2121	filed within Hygiene. other then "	Completed	Elementary/Secondary (0-12) SHA QVade	College (1-4or 5+)		rsun	g A	sistar	rt	Hea	lthcar	re
Maryland	uld be file Aental Hy rked oth Ilc event	To Be (17. Father's Name (First, Middle, Last) Henn Smith	h					lame (First, Middle,		e)	
lary	2 short		19a. Informan ame/Relationship (7		19b. Maili			1	Rural Route Number	D		
	1 and Health em 27 ther tr		20a. Method of Disposition	Mother	b. Place of Dispo		l Man	1 Ave	enue.	20c. Location - 0		MD 21213
mor	Pages nent of int: if its iry or o		1 ☐ Burial 2 🗷 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, cre VEENW	matory or	other place	03	15/06	Balti		
Baltimore,	permit Page Department of Importent; if any injury of		21. Signature of Funeral Service Licens					s of Facility reene F Road	uneral : Baltimi			1
- 0			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the done cause on each line.							Appi	roximate val Between et and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. ENC.	EPHAL	ITIS	~ E.	acephal.	pathy		Orisi	et and Death
	Examiner				sequence of):				/			
7	p ii	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence of):							
<i>V</i>	cate be executed physicien and the burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as a con:		GB	AID	کر			_	
8760,	ysicier ysicier	dlcal		d								
9	entifica ing phi e as th	Medi	IF FEMALE:		_							unere use
O. Box	that the death certificed by the attending of detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	⊒Ectopic p ⊒ Other (s				23d. Date Mon	of delivery th Day	Year
, P.O	requires that the een signed by thi nould be detache	by Ph	Part II. Other significant conditions co	ontributing to death but not	resulting in the u	underlying	cause give	n in Part I.	23e. Did t	obacco use contri	bute to the cau	use of death?
ords	w requires been sign should be	ted b	Neutripanii	CMV R	e tinitis				_ 10'	Yes 2□No	3 ☐ Probably	4 Dunknown
ecc	> Q to	Completed							24a. Was	an 24b. W	Vere autopsy fi	ndings available ion of cause of
alF			25.14			111,00			1 ☐ Yes	21 No 1	eath?	No
₹	Physicien: this certificatal director, I	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 4	2 C ER/Outpatie	nt 3 🗆 🗅	Othe		Death (Check only of g Home 5 ☐ Residue		r (Capata)	
Jo L	<u>a</u> = <u>a</u>		27. Manner of Death	28a. Date of Injury (Month, Day Year	28b. Time o		28c. Injury Work			now injury occurre		
siol	Attending r death. ector: After oy the fune	catic	1			М	1 🗆 1	res 2 □ No				
Division of Vital Records,	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, st ecify)	treet, facto	ry, office		28f. Location (: City or To	Street and Numbe vn, State)	er or Rural Rou	ite Number,
	Hospil 24 hour Funer etely fills	Medical	29a. Certifier 1 Certifying Ph. (Check only one)	ysician: To the best of my iner: On the basis of exam and manner stated.	knowledge, deal nination and/or in	th occurred evestigation	d at the tim n, in my op	e, date and pla einion, death of	ace, and due to the courred at the time,	cause(s) and mar date and place, a	nner as stated. nd due to the	cause(s)
	To the within To the Compl	Me	29b. Signature and title of certifier				ec. License			29d. Date signed	(Month, Day,	Year)
			A Lax	1	m D		Do00	52634		3/14/0	6	
	3		30. Name and address of person who		Item 23a) (Type	Print)	(A)	FEDD:	R: 40	DAIT	IM. ac	44.4.2
	Sta	te.	MATEEN 31. Date filed (Month, Day, Year)	AWAN 271' 32. Registrar's Si		THEN	,,,,	1 12121	10 179	らクレー	MIXE	1117 2122
	Registr			2006	20	1 4						

		1 - For State Registrar	State of Man		artment of Health <i>rtificate of Deatl</i>		rgiene	06	081	83
Ø 3		Decedent's Name (First, Middle, Last)			2. Date of D			3. Time of	Death
Physici Medid/			Oscar Sti	egler		March	13,	2006	7:55	A^N
Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Location	of Death		ty of Death		
		Brighton Gardens	3		North Bethe	esda	Mon	tgome	ry	
uneral		Social Security Number 6. Se	ØM 2□ E	n yrs. last birthday,	if Under 1 Year If Under Months Days Hours	Min (Month D.	rth	9. Birthp	lace (State or	Foreig
irector		3/0-40-8903	X M 2□F 1	02 Yrs.		February	24, 1904	4 Mary	land	
*		Usual Residence of Decedent 10a. State 10b. County	11	Oc. City, Town or L	ocation			1	Od. Inside Cit	v Limit
a pa	ō								1 Tes	•
28a-	ect	Maryland Montgome 10e. Street and Number	ry	North Be	10f. Zip Code		10g. Citizen of	Mhat Cour	atn/2	
10 es	Ö	5550 Tuckerman La	220		20852				•	
ne 2	Funeral Director	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.		origin? (Specify Yes or N	United	State		
r la	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 X Yes 2 ☐ No	WWLI	Was Decedent of Hispanic C If Yes, specify Cuban, Mexic		BI	ack, White,	etc.	
o la	Ď	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates: Ko	orean	1 ☐ Yes 2 X No Specif	y:	Spec	ity: Wh	ite	
"natural", or Itame 23a or 28a-1 show solical Examinat must be notified at	Completed	15. Decedent's Edu	ucation	16a. Dece	dent's Usual Occupation	ant of words a	16b. Kind of	Business/Ind	dustry	
	pie	(Specify only highest grade Elementary/Secondary (0-12)		Nava1	kind of work done during mo DO NOT use retired) Officer/Nava	oscor <i>working</i> 1 Architectur	Unit	ed Sta	ates	
	no.		College (1-4or 5+) 5+	and M	DO NOT use retired) Officer/Nava arine Enginee	r	Na Na	vy		
	Be (17. Father's Name (First, Middle, Last)				her's Name (First, Middle		(me)		
	2	Sylvester Stiegl	er		Jo	sephine Jan	da			
T S T		19a. Informant's Name/Relationship (T)	ype, Print)	19b. Maili	ng Address (Street and Num.	ber or Rural Route Numb	er, City or Town	n, State, Zip	Code)	
Itam 27 other tra		James H. Stiegler		6606	Carleton Cour		Marylar	d 207	07	
		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F	Romaval from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place)	July 5,	20c. Location	- City or To	own, State	
Important: I eny Injury o once.		4 □Donation 5 □ Other (Specify)		Arlington :	National Cemeter		Arlingt	on, V	rgini	.a
Important: eny Injury o pnce.		21. Signature of Funeral Service bicens			Name and Aderess of Fac					
Ē € 월		MageletteBary	west -	M01305 7	557 Wisconsin Ave	nue, Bethesda,	Marylan	d 20814	4−3501	LIC.
sician		23a. Part1. Enter the disease, or comp. shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)		e death. Do not en ular Arrh		s cardiac or respiratory a	rrest,	5	Approximate Interval Betwonset and D Minut	veen eath
edical iminer	ner	Sequentially liet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c Congest Due to (or as a c	ive Heart	Failure			5	Years	
ysician and e burial-transit	cai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a c	onsequence of):						
g ph) as th			•							
led by the attending physi detached for use as the t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			ate of delive Ionth		ear
deta deta		Part II. Other significant conditions co.	ntributing to death but n	ot resulting in the u	inderlying cause given in Part	I. 23e. Did	tobacco use cor	ntribute to th	ne cause of de	ath?
sign d be	d by	Atrial Fibrillat					Yes 2. No	3 ☐ Prob	ably 4 ∏Ui	nknow
been signe should be	ete									
page 2	Completed					24a. Was auto perfo	psy ormed?	prior to cor death? 1 \(\subseteq \text{Yes}	psy findings a npletion of ca 2 \(\text{No} \)	vailabl use of
is certific director,	Be	25. Was case referred to medical examiner?	Hospital:			e of Death Check only			Assiste	ed
	2	1 ☐ Yes 2 📉 No	1 🗀 Inpatient	2 ER/Outpatie	IL 3 DOA 4 IN	Jursing Home 5 Res	dence 6 ∑Ot how injury occu		Living	
Afte	tion	1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	ear) Injury	f 28c. Injury at Work? M 1 ☐ Yes 2 ☐		no n injury occu	1160		
the the	Certification;	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	. At home farm et			Street and Num	that or Pura	I Pouto Numb	
<u>a</u> ⊆	E I	4 Homicide determined	building, etc. (Specify)	reet, factory, office	City or To	wn, State)	iber or nura	I HOULE IVUIND	Θ1,
8 P	dical C	29a. Certifier 1 & Certifying Phy (Check only one)	sician: To the best of ner: On the basis of exand manner stated	amination and/or in	h occurred at the time, date a vestigation, in my opinion, de	and place, and due to the eath occurred at the time,	cause(s) and m	anner as st , and due to	ated. the cause(s)	
Fune etely til	0		. 1	-	29c. License number		29d. Date sign	ed (Month, I	Day, Year)	
o the rune ompletely til	Med	29b. Signature and title of certifier							,/	
completely til	ω .	29b. Signature and title of certifier	en		D0022864		March 1	14 20	006	
To the Funer completely til	ω .	1 Joston	la		D0022864		March 1	14, 20	006	
To the Funeral Director: Atler the completely tilled in by the funeral	ω .	30. Name and address of person who co			Print)	Marvil 3		14, 20	006	
To the Funer completely til	Ме	1 Joston		nsin Ave		, Maryland 2		14, 20	006	

06-01791 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Eric V. Studtmann State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 13, **Physician** Day 2006 Year 0458 A. M Eric William Studtmann /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rt. 24 @ 924 Abingdon Ha If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Harford 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Director 449-83-6004 33 March 23, 1972 Illinois Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location ahow. 10d. Inside City Limits' Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hyglene.
ant: if item 27 Is marked other than "natural; or itema 23e or 28e-f show ury or other traumatic avent, the Medical Examples must be notified at 1 Yes 2 No Directo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 801 Redfield Road 21014 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. ☐Yes 2 XNo 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No f Yes, Give Year or Dates: Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Chef Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert William Studtmann Linda Katherine Milhousen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 801 Redfield Road, Bel Air, Maryland 21014 Teresa L. Studtmann / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Darlington Cemetery 3-17-06 Darlington, Maryland 22. Name and Address of Facility Home, P.A. 21. Signature of Fuperal Service Licenses 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician reack IM /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physiclen and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? ģ Month Year Day signed by the a 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Be Completed by this certificete hes been siral director, page 2 should 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

12 Yes 2 □ No 24a. Was an autopsy performed? Division of Vital 1⊠ Yes 2□ No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death | Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1√2 Yes 2 No ပ္ 1 | Inpatient 2 ER/Outpatient 3 DOA scene funeral 28a. Date of Injury (Month, Day Year) 5/13/06 28d. Describe how injury occurred Decoased driving Struck brother Certification; 27. Manner of Death 28b. Time of 28c. Injury at Work? reliable that FOUND SOAM 1 Natural 5 Pending death. 1 ☐ Yes 2 No investigation velice 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, slreet, lactory, office building, elc. (Specify). 28. Location (Street and Number or Rural R ute Number City or Town, State) P.1. Z.4 924 About don Horror Co. M. ģ 4 - Homicide filled in t Hospital within 24 hours (To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

12

31. Date filed (Month, Day, Year)

30. Name and address of person who completed

2005

32. Regislrar's Signature

cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore Maryland 21201

March 13, 2006

Registrar
DHMH 17 Rev 1/2001

State

O.C.M.E.

800)		i icase i j	Chata of Mandan	d / Dana		A ~ £ 1.1	a altha a	nd M	ontal Live	niono		•			
			For	State of Maryland					ina ivie		/")	000	00	0.5		
					Cer	tificate	e or L	Jealii		2 Date of Dea	Reg. No.	UUT	3. Time o	65		
	Physici	an	Decedent's Name (First, Middle, Last)	7						MARCH		2006 €		Ам		
	/Medic	al	Donald Lee Shafer,			41 0'5	T			LIMICII		County of De				
4	Examin	er	4a. Facility Name (If not institution, give st 950 PENTWOOD ROAD A		-	BELAI		Location o	i Death			ARFORD				
			5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under		If Under 2	24 Hrs.	8. Date of Birt	h	9. 8	Birthplace (State	or Foreian		
	Funeral Director			M 2□F 61	Yrs.	Months		Hours	Min.	July 2	y, Year)		^{Country)} ennsylva	_		
			Usual Residence of Decedent													
	ylan how		10a. State 10b. County	10c. City	, Town or Loc	cation							10d. Inside C			
	e-f-	cto	Md. Harford			Ве	1 Ai	r						2 □ No X		
	within 72 hours after death with the Maryland ene. Then "natural", or Itame 23e or 28e-f ehow he Medical Exancinar must be notified a	by Funeral Director	10e. Street and Number			10f. Zip		01/			10g. Citiz	en of What	-			
	23a	la l	950 Pentwood Road,					014				U.S.				
	temet	- In	11, Marital States	Was Decedent Ever in U. Armed Forces?	S. 13. V	Vas Deced Yes, spec	dent of Hi	spanic Orig n, Mexican	gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)	. 1	14. Race - American Indian, Black, White, etc.				
36	s afte	Y.	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	I ☐ Yes	2 🔀 No	Specify:				Specify: White				
8	hour	pa p	15. Decedent's Educa		16a. Deced	lent's Usua	al Occupa	ation			16b. Kir	nd of Busine	ss/Industry			
<u>.</u>	in 72	Set	(Specify only highest grade	completed)	(Give	kind of wo	rk done a	furing most	of workin	19	accounting/auditing					
12	ther.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 4	certif	fied	pub1	ic ac	coun	tant	(self-employed)					
D	Hyg other	Be C	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle,	Maiden :	Sumame)				
<u>a</u>	ld be fenta fred tice	To B	Donald L. Shafer,	Sr.				Mar	jori	e Ditzl	zler					
Maryland 21215-0036	short and A	-	19a. Informant's Name/Relationship (Typ							Route Number						
Σ	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental hygiene it from 27 is marked either then "natural", or Itame 28s or 28s-1 show other traumatic event, the Medical Examinar must be motified at		Donald L. Shafer I	•				oa ko		Baltimo						
Baltimore,	of He of He roth		20a. Method of Disposition 1 ☐ Burial 2 【※Cremation 3 ☐ Re	۰ ا	lace of Dispo: emetery, cren	sition (Nar natory or o	me of other place	θ)		ate			or Town, State			
<u>Ĕ</u>	Pag ment: f ant: f		4 □ Donation 5 □ Other (Specify)	Bay	yview (Crema	tory	1	3/16	/2006	Bal	timor	e, Md.			
at	permit. Pages: Department of H Important: If ite any Injury or ot		21. Signature of Funeral Service Licenses	-1	22	Name ar	nd Addres unek	s of Facilit	ral 1	Home of	Be1	Air,	Inc.			
_	207		Mul		1 6	510 W	. Ma	cPhai	1 Ro	ad. Bel	Air		21014			
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death cause on each line.				/					Approxima Interval Be Onset and	rween		
	Physician		Immediate Cause (Final disease or condition	Hubritarive	the	rosdo	nti	i (a	Dió ve	sculer	-14	Eur C				
•	/Medical Examiner		resulting in death)	Due to (or as a consequent	uence of):											
	LAdimici		Sequentially list conditions, b.	Due to /or as a consequence of):												
1	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a consequ	Due to (or as a consequence of):											
d	be executed icien and burial-transit	хап	that initiated events c. resulting in death) Last	Due to (or as a consequence	uence of):											
,092	ate be executed hysicien and he burial-transit	calE														
687	ficate phys s the		d.													
Box (death certificate e attending phy ed for use as the	M	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregna		1					2	3d. Date of	delivery			
ă	d for	clai	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Feta 4 Pregnant at time of d]Ectopic po]Other (sp						Month	Day	Year		
0	by the de	Physician/Med	9 🗆 Unknown	9□ Unknown						_						
۵.	The law requires thet the tie has been signed by th bage 2 should be detache	by P	Part IL Other significant conditions conf	inbuting to death but not res	ulting in the u	nderlying	cause give	en in Part I		23e. Did t	obacco u	se contribute	e to the cause of	death?		
Vital Records,	w require been sig should b	ed	Pulmorary Hype	tersion						10	Yes 2	□No 3	Probably 4	JUnknown		
O O	aw requas been 2 should	Completed	Read Fasia	Strency						24a. Was		24b. Were	autopsy findings to completion of	available		
æ	The lay	Eo	(Ate	destism						perfo	rmed? 2 ☐ No	death		00000		
ita		0	25. Was case referred to medical	oro (isin				26. Place	of Death	(Check only						
f V	yeic nis ce direc	To B	examiner? 1 X Yes 2 □ No	ospital: 1 🗌 Inpatient 2 🔲	ER/Outpatien	nt 3□ D(OA Oth	er: 4□Nu	ırsing Hon	ne 5∐ Resi	dence 6	S ∭Other (S	Specify) SCE	NE		
n of	ng Ph ter th neral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 2	28c. Injun Work	y at k?	2	28d. Describe	how injur	y occurred				
<u>Ö</u> .	ttendir death. ctor: Al y the fu	atle	2 Accident investigation			М	10	Yes 2								
Division	al or Attending F safter death. I Director: After d in by the funera	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify		eet, factor	y, office		2	28f. Location (City or To			r Rural Route Nu	nber,		
Ω	Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certific tely filled in by the funeral director,															
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	29a. Certifier 1 Certifying Phys (Check out) 2 Medical Examin	ician: To the best of my kno er: On the basis of examina	wledge, death tion and/or in	n occurred vestigation	at the tin	ne, date ar pinion, dea	id place, a ith occurre	and due to the ed at the time,	date and	and manner place, and	r as stated. due to the cause	(s)		
	To the I within 2 To the I complet	Med	29b. Signature and title of certifier	and manner stated.		29	c. Licens	e number			29d. Dat	e signed (M	onth, Day, Year)			
	T ¥ D		Y and L	lo un				CME				н 14,				
			- Carron	remo	- 02-1 (7	Dric4)						,				
	20		30. Name and address of person who con	Marie AA D			EMM 9	ידים פידיב	T. R4	TTTMOR	E.MA	RYLANT	, 21201			
7	St.	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature .		TTTATA Y		<u> </u>		-,		,			
	Regist		MAD 1 7 2006	Acres 12	Care se	1										

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death March 9. Day 006 **Physician** James Mitchell Sexton 1158 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bel Air Harford Upper Chesapeake Medical Center 8. Date of Birth
(Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Months Country) Virginia 1944 Director 218-40-8593 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location tem 27 is marked other then "naturel", or Items 23a or 28e-1 show other traumatic event, the Madical Examinar must be notified at Bel Air 1 ☐ Yes 2 No Md. Harford Director 10f. Zip Code 21014 10g. Citizen of What Country? 10e. Street and Number 806 Chesney Lane death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours efter ☐Yes 2 ☑ No Yes, Give 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: white Specify: ģ If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 72 th and Mental Hygiene. 7 Is marked other then "ne Efementary/Secondary (0-12) Colfege (1-4or 5+) stone quarry equipment operator 9 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Margie Musser Grover Brown Sexton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If Item 27 Is: ury or other traus 1041 Wingate Court, Bel Air, Md. 21014 Michael Sexton/brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 3/14/2006 Bel Air, Md. Bel Air Mem. Gdns. 4 ☐ Donation 5 ☐ Other (Specify) permit.
Departrimental
Importal
any nju 21. Signature of Funeral Service Licensee Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiopulmonary **Physician** /Medical Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Due to (or as a consequence) P.O. Box 68760. ed by the attending physicien detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. ģ 90 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy 1 ☐ Yes 25 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death [Check only one] Hospitaf: Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\)Other (Specify) 1 ☐ Yés 2 No 1 🔲 Inpatient 2 X ER/Outpatient P 3 DOA this 28c, Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of fnjury 27. Manner of Death 28d. Describe how injury occurred Certification: Division To the Hospital or Attending 1 Natural 2·□ Accident 5 Pending investigation after death. М 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medicai and manner stated within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 520 m.D. inne Einbinder Registrar's Signature State Registrar

			1 = For State Registrar	State of M	faryland / [Depart <i>Certif</i>	ment of H ficate of L	ealth a Death	ınd Ment		jiene	06	08187	
	Dhysia		1. Decedent's Name (First, Middle, Last)						ate of Dea	th Day	Year	3. Time of Death	
	Physic /Medi		John Edward Sears	3						3	12	06	10:33 PM	
	Exami	ner	4a. Facility Name (If not institution, give	13		4t	b. City, Town, or			MI	1	nty of Death		
			GOOD SAMARITAN	HOSPITA					21239			n/a		
	Funeral Director		5. Social Security Number 6. Se 030-26-1731	X JM 2□F / A	ge (In yrs. last bin		Under 1 Year lonths Days	If Under 2 Hours	Min. (M	te of Birth fonth, Day	Year)	Cou	place (State or Foreign intry)	
			Usual Residence of Decedent	7	70					-27-	1935	Mas	<u>sachussetts</u>	
	yland		10a. State 10b. County		10c. City, Town	n or Locati	ion						10d. Inside City Limits	
	a-fel	tor	Maryland n/a		Baltimo	re							1 X Yes 2 □ No	
	or 28	ire	10e. Street and Number				10f. Zip Code			1	0g. Citizen o	of What Cou	intry?	
	23a	ai	2708 Overland Aver	nue		12	21214-28	349		Į	J.S.A.			
	tems terms	Funeral Director	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S. ?	13. Was	Decedent of His	spanic Orig	in? (Specify Y	es or No-		ace - Ameri lack, White,		
36	s afte	by Fu	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 If Yes, Give		1	Yes 2X No	Specify:		,		city: Wh:		
ô	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or Items 23e or 28e-f ehow int, I're Medical Examinar must be notified at	ed b	15. Decedent's Edu	Year or Dates:		Decedent	's Usual Occupa	tion						
15	in 72 n "na Aedic	Completed	(Specify only highest grad	e completed)		(Give kind	d of work done d NOT use retired)	urina most	of working		16b. Kind of	Business/In	idustry	
212	igne.	E O	Elementary/Secondary (0-12)	College (1-4or	*		ve Sport		itor	Ŧ	Raltim	ore Si	unpaper	
b	e filec Il Hyg othe vant,	Be C	17. Father's Name (First, Middle, Last)		- Jake	Cuci			's Nam <i>e (Fir</i> st				шрарет	
ılar	nould be filed within I Mental Hygiene. narked other than ' natic avant, II's Me	0	William Gerald Sea	rs, Sr.				Ethe1	l Slatt	ery				
<u></u>	and and			rpe, Print)										
	and ealth n 27 nar tr		Jeanne Sears/Wife		27	08 Ov	verland	Avenu	ıe, Bal	timor	e, Ma	rylano	1 21214	
Baltimore,	it of He		20a. Method of Disposition 1XXBurial 2 Cremation 3 DE	Removal from State	aamatar	Dispositio y, cremato	n (Name of any or other place)	Date		20c. Location	n - City or To	own, State	
Ë			`4 □ Doffation 5 □ Other (Specify)											
3alt	permit. Pa Departmer Important any Injury	William Gerald Sears, Sr. Sthel Slattery												
	707 E 48 OI		(18 19 Com			641	l5_Belai	r Roa	ad, $Ba1$	timor	e, MD	2120		
			23a. Part1 Enter the disease, or compt shock, or heart failure. List only or	ications that cause ne cause on each i	d the death. Do n line.	not <i>e</i> nter th	ne mode of dying	, such as c	ardiac or respi	iratory arre	est,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition resulting in death)	1	INTRA	CRAN	IAL HEN	10 RRH	AGE				Onset and Death	
	/Medical Examiner		Toolsting in dough)	Due to (or as	a consequence o	. ,.			1 00					
		e.	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of		ION, A	FTIZIAL	. FISRI	LLA71	CN			
V	uted Insit	min	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			,-								
.	be executed sician and burial-transit	Examin	that initiated events resulting in death) Last	Due to (or as	a consequence o	of):				_				
8760,	cate be executed physician and the burial-transit	dical		1										
68	tifica ng ph as th	led												
Вох	eath certific attending p	Physician/Me	230. Has decodoril program	3c. If yes, outcome	of pregnancy 2 Fetal death	3 DEat	opic pregnancy				23d. D	ate of delive	ery	
). E	e dea he att	slci	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a			ner (specify)				,	Month	Day Year	
P.0	that the de led by the a detached	Phy	9 Unknown											
S,	og og	by	Part II. Other significant conditions cor ĈAD , CANC		SLADDE L	the under		n in Part I.	23				he cause of death?	
oro	w requir been si should	eted	CAD CANC	ek or i	CHUUSK	1 9, 11	<u> </u>			1 Ye	s 2 No	3 Prob	pably 4 Munknown	
of Vital Records,	elaw hast je2s	Complete							24	la. Was ar autops	v /	prior to co	psy findings available mpletion of cause of	
a		I - F							10	perform Yes 2	No No	death? 1 ☐ Yes	2□ No	
Z.	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	lospital:			Other	~	of Death (Chec					
of		1: To	1 Yes 2 No	28a. Date of Init	IDV 28b T		LIDOA	4 🗆 Nurs	sing Home 5		nce 6 0		y)	
O	ding th: Afte fune	tlor	1 □ Natural 5 □ Pending 2 □ Accident investigation	(Month, Da	y Year) In	ijury	28c. Injury : Work? M 1 ☐ Ye	;" es 2 □ No		9301100 110	w injury occi	illed		
Division	Attending ir death. ector: After by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of In	jury - At home, fan				28f. Lo	cation (Str	eet and Nun	nber or Rura	al Route Number,	
ă	el or A s after Il Dire	Certification;	4 Homicide	building, e	tc. (Specify)				Cit	y or Town	, State)			
	spite hours unera y fille		29a. Certifier 1 Certifying Phys	ician: To the best	of my knowledge,	, death occ	curred at the time	, date and	place, and due	e to the ca	use(s) and n	nanner as s	tated.	
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Examir one)	and manner st	of examination and ated.	Vor investig	gation, in my opi	nion, death	occurred at th	ne time, da	ite and place	, and due to	the cause(s)	
	To the Hospitel or A within 24 hours after To the Funeral Dire completely filled in b	Σ	29b. Signature and title of certifier	n M-D			29c. License			29	9d. Date sign		Day, Year)	
•			b findage				,	000			3/	12/06		
	Di		30. Name and address of person who co		leath (Item 23a) (Type, Print	d 4.12.	שני ש	0.32	0 2	71		415	
	1		SANDER HAY 31. Date filed (Month, Day, Year)			OCH	RAVEN	DCV+)	2125	1, 5	HLIIN	CKE	, MJ	
	Sta Registr	1	ST. Date filed (Mornin, Day, Year)	Jz. Hegisti	rar's Signature	Set 1								

			For State	State of Marylar		ent of Health an	-	4000	08188
135	Physici	20	Registrar 1. Decedent's Name (First, Middle, Last)	Α	1-11		2. Date of Dea		3. Time of Death
	Physici /Medic	al	4a. Facility Name (If not institution, give s	esa Ang		m do	3-10	4c. County of Deal	6:58PM
	Examin	er	21 Craftsman	Court	K	7	own	0 1	timore
	Funeral Director		5. Social Security Number 6. Sex	M 2 T. Age (In yrs.	last birthday) If Und Month	er 1 Year If Under 24 s Days Hours	Hrs. 8. Date of Birt Min. 9-16-	1964	hplace (State or Foreign
	D D		Usual Residence of Decedent 10a. State 10b. County	100 00	Town or Lecation			- 707	10d. Inside City Limits
	Maryla	tor	114 77 11.	zore K	eister	stown			1 Tyes 2 No
	d within 72 hours after death with the Maryland piene. rr than "natural", or Itema 23a or 28a-f ehow Ina Medical Examinat must be notified at	Director	10e. Street and Number	1 +		21/36		10g. Citizen of What Co	untry?
	death	Funeral	al Crattsman 11. Marital Status	2. Was Decedent Ever in U	I.S. 13. Was Dec	sedent of Hispanic Origin becify Cuban, Mexican, F	? (Specify Yes or No	14. Race - Ame Black, Whit	
36	hours after tural', or ite	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		2 No Specify:	corto i nocin, otc.)	Specify: B	lack
2-00	72 hou nature	eted	15. Decedent's Educ (Specify only highest grade		16a. Decedent's Us (Give kind of	vork done during most of	working	16b. Kind of Business	Industry
21215-0036	d within giene. er than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Execu-	ve Assi	stant	Health	Care
	the filed ortal Hygined ed other	Be	17. Sether's Name (First, Middle, Latt)	ward	•	1111	Name (First, Middle,	Maiden Sumame)	lan
Maryland	s 1 and 2 should be filed I Health and Mental Hyg item 27 is marked othe other traumatic event,	၉	19a. Informant's Name/Relationship (Typ	00, Pr ()	19b. Mailing Addr		r Arral Route Numbe	er, City or Town, State, 2	Zip Code)
-	tem 27		Andre L. Inoma. 20a. Method of Disposition	20b. I	Place of Disposition (A	sman Ct.	Neisters to	20c. Location - City or	Town, State
Baltimore			1 ☐ Burial 2 A Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, cremetory o	other place)	13/2006	Baltimo	re, m)
Balt	permit. Page Department of Important: If eny Injury or		21. Signature of Funeral Service Licens	Greene	22. @. (5(5)	Batto. Nat	1. Pike t	salto, mo	
.7%			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final	cations that caused the deal e cause on each line.	th. Do not enter the m	ode of dying, such as cal	rdiac or respiratory ar	rest,	Approximate Interval Between Onset and Death
12	Physician /Medical		disease or condition resulting in death)	Due to (or as a consec	quence of):	3			
40	Examiner	7	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	Cance	1			
V	ocuted nd transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events						
8760,	death certificate be executed e attending physicien and of for use as the burial-transit	dical Ex	resulting in death) Last	Due to (or as a consec	quence of):				
9	ntificate I	Medic	IF FEMALE:						
Вох	leath certific attending pl	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3 ☐ Ectopic			23d. Date of del Month	ivery Day Year
P.O.	by th	Physi	9 Unknown	9□ Unknown					
	es Ded	þ	Part II. Other significant conditions con	tributing to death but not res	sulting in the underlying	g cause given in Part I.		obacco use contribute to Yes 2 □ No 3 □ Pr	
of Vital Records,	s b	Completed					24a. Was	an 24b. Were au	itopsy findings available completion of cause of
a E	The ate h page						perfo 1 Tes	rmed // death?	2 No
V.I.	Physician: 1 this certifical	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	ER/Outpatient 3	Othor	Death (Check only o	one) dence 6 □Other (Spe	cufy)
n of	ing Ph	lon: T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe h	how injury occurred	
Division	Attending ir death. •ctor: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fact	1 ☐ Yes 2 ☐ No ory, office		Street and Number or Ru	ural Route Number,
۵	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.								
	the Hospi hin 24 hour the Funer npletely fill	Medical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examination)	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and pon, in my opinion, death	place, and due to the occurred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To the within 2 To the complet	×	29b. Signature and title of certifier	Ω	2	29c. License number		29d. Date signed (Mont	h, Day, Year)
	01		30. Name and address of person who co	mpleted cause of death (Itel	m 23a) (Type, Print)	D33466	7	3-13.0	6
	1,		Eleanory.	Hxm nd					
4	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 7 2006	37. Registrar's Sign	ature document				

	1 - State Registrar		/ Department of Health and Certificate of Death	Reg.	<u>2006 08189</u>							
Physician	1. Decedent's Name (First, Middle, Las			2. Date of Death Month MAR . 11,	Day Year 3. Time of Death							
/Medical	FERDINAND F. TA 4a. Facility Name (If not institution, give		4b. City, Town, or Location of Deat		2006 4:45 P							
Examiner	STELLA MARIS	siroti and ridinosiy	TIMONIUM		BALTIMORE							
uneral irector	213-01-0031	7. Age (In yrs. last	birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, Ye AUG. 25,	9. Birthplace (State or Forei Country) MD .							
*	Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Location		10d. Inside City Limi							
or items 23s or 28e-f show sminer coust be notified at y Funeral Director	MD. BALTIMO	RE	COCKEYSVILLE		1 ☐ Yes 2 [X]N							
be nutified	10e, Street and Number		10f. Zip Code		Citizen of What Country?							
erai	701 IBY HILL RD.	12. Was Decedent Ever in U.S.	21030		ITED STATES 14. Race - American Indian,							
ninerawii Funeral	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 Dyes 2 No 1946 If Xes, Give	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	o Rican, etc.)	Black, White, etc.							
0	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: 1947	1 ☐ Yes 2 ☑ No Specify:		Specify: WHITE							
Completed	15. Decedent's Ed (Specify only highest grad	ucation 1 de com <i>pleted)</i>	 Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired) 	rking 16t	. Kind of Business/Industry							
E G	Elementary/Secondary (0-12) 12TH	College (1-4or 5+)	AERONAUTICAL ENGINEER		MARTINS							
Be C	17. Father's Name (First, Middle, Last)			πe (First, Middle, Mai								
To B	CHARLES TAYLOR		ROSE ZO	RN								
treumatic event.	19a. Informant's Name/Relationship (7	· ·	19b. Mailing Address <i>(Street and Number or Ri</i>									
	DANIEL ZIEGFELD/NEPHEW 701 IBY HILL RD., COCKEYSVILLE, MARYLA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - Cit											
	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SACRED HEART OF JESUS 3/16/06 BALTIMORE, MARYLAND											
	4 Donation 5 Other (Specify) SACRED HEART OF JESUS 3/16/06 BALTIMORE, MARYLA 21. Signature of Funeral Service Lisensee 22. Name and Address of Facility CHARLES S. ZEILER & SON, II											
any injury or ol ODCS.	Leader 1	70xx	6224 EASTERN AVE.		The second secon							
	23a Part Venter the disease, or comp	dications hat cause the death. I	Do not enter the mode of dying, such as cardia	or respiratory arrest,	Approximate Interval Between							
ian	Immediate Cause (Final disease or condition	a PNEUMONIA			Onset and Death							
cal ner	resulting in death)	Due to (or as a consequen	ce of):									
	Sequentially list conditions, if any, leading to immediate	b. — Due to /or one										
nine	Cause (Disease or injury	Due to (or as a consequen	ce or).									
Examiner	that initiated events resulting in death) Last	c	ce of):									
cai		d.										
or use as the lan/Medica	IF FEMALE:											
etached for use as the Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 ☐Ectopic pregnancy		23d. Date of delivery Month Day Year							
		ontributing to death but not resulting	ng in the underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?							
اه ا		_		1 ☐ Yes	2 No 3 Probably 4 Number							
Completed				24a. Was an	24b. Were autopsy findings availal							
Page 2				autopsy performed 1 ☐ Yes 2 X	prior to completion of cause of							
ig. p	25. Was case referred to medical		26. Place of De	ath (Check only one)	NO ILITES ZLINO							
To Be (examiner? 1 ☐ Yes 2 ሺ No	Hospital: 1 ☐ Inpatient 2 ☐ ER	/Outpatient 3□ DOA Other: 4X Nursing H	lome 5 Residence	e 6 ☐Other (Specify)							
	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury 28 (Month, Day Year)	b. Time of 28c. Injury at 1 Work?	28d. Describe how i	njury occurred							
cati	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No									
ed in by the funera Certification;	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, office	City or Town, S	t and Number or Rural Route Number, tate)							
completely filled in by the Medical Certifica			dge, death occurred at the time, date and place and/or investigation, in my opinion, death occu									
Me	29b. Signature and title of certifier	and marrier stated.	29c. License number	29d.	Date signed (Month, Day, Year)							
9	• /	-	カイスファト		3/13/06							
			- 1 7 7 2 3									
2	30. Name and address of person who o	completed cause of death (Item 23	Ba) (Type, Print)									

DHMH 17 Rev 1/2001

MARCH 11, 2006 4:45 p.m.

FERDINAND TAYLOR

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** laratsides 06:15 AM maioti 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A HOSP 15 Johns HOOKINS Itemore 8. Date of Birth (Month, Day, Year) AUG. 26, 1928 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1₩ 2□F Months Hours Yrs. 212-56-7873 GREECE Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County in than "netural, or Iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No EASTPOINT Director MD. BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 522 S. 48TH STREET 21224 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 21 No If Yes, Give X Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: ģ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) VENDOR SELF EMPLOYED 2ND. 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental I Pages 1 and 2 should be GEORGE TARATSIDES DESPINA AMANATIDOU 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a importent: if item 27 is any injury or other trainant. GEORGE TARATSIDES/SON 522 S. 48TH STREET, BALTIMORE, MARYLAND 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) OAK LAWN CEMETERY 3/14/2006 BALTIMORE MARYLAND 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signa are of Furieral Service Licens 6224 EASTERN AVE., BALTIMORE, MARYLAND 23a. Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician umonia ? days /Medical Due to (or as a consequence of) Examiner Cholangitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque Examiner or Attending Physician: The law requires that the death certificate be executed physicien and s the burial-transit uncreati Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, idifferntiako odenocorcinoma Physician/Medical the 23c. If yes, outcome of pregnancy 1☐Live birth 2☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 2 No 1 Yes : After this certification a funeral director. 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death | Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Dath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation s after de-ral Director: After 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be within 24 hours after de To the Funeral Directo completely filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and Aitle of certifier Res - 000 3 Hookins Hospital, LOW North Wolfe Street, Maryland 21287 32. Registrar's Signature State Registrar

			1 - State Registrar	State of Ma	arylan			Health and N f Death	Mental Hy	giene Reg. Ne.	306	08191
			Decedent's Name (First, Middle, Last)						2. Date of De	ath		3. Time of Death
	Physici		Joseph G. Vinci						Month	Day	Year	2;00 PM
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4	b. City, Town	, or Location of Death		4c. C	County of Death	n
	LAGITHI		Balt: more Washir	raton T	redic	al Conten	Glo	Burnic		A	nnef	trundel
6	Funeral		5. Social Security Number 6. Sex			A	If Under 1 Yes		8. Date of Bi	av Yearl	Co	nplace (State or Foreign untry)
0	Director		212-14-0134	M 2□F	86	Yrs.			May 22	2, 19.	19 Mar	yland
9	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	v. Town or Locat	tion					10d. Inside City Limits
Ö	show	5	Maryland Anne Arun	4.1		,,						1 ☐ Yes 2 ☑ No
T/	the Maryla r 28e-f show	Director	10e. Street and Number	idei	56	everna P	10f. Zip Code			10g Citiz	en of What Co	untry?
. 1	늘 호및	급	509 Nowrich Rd.				21146					•
9	eath w	Funeral		2. Was Decedent	Ever in II	S 13 Wa		of Hispanic Origin? (Sp	pecify Yes or N		ed Stat 4. Race - Ame	
ما.	ter dea	Š	1 Never Married 2 Married	Armed Forces? 1 Armed Forces?		lf Y	es, specify C	uban, Mexican, Puerto	Rican, etc.)		Bfack, White	e, etc.
7 88	irs aft	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		[I 1]Yes 2⊠IN	lo Specify:			Specify: W	hite
Ą	natural',	ted	15. Decedent's Educ	ation		16a. Deceden	nt's Usual Occ	cupation	kına	16b. Kin	d of Business/	Industry
215	Med Med	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. DO	NOT use ret	ne during most of work ired)	n'''y			
7	od wit gjene er th	Completed	8			Assemb	ly Wor				omotive	
멀	be filed within 72 hours after ital Hyglene. Ind other than "natural", or ite event, the Medical Examina	Be (17. Father's Name (First, Middle, Last)					18. Mother's Nam	ne (First, Middle	, <i>Maid</i> en S	Sumame)	
<u>8</u>	S should be filed within and Mental Hygisne. Is marked other than aumatic event, the Manager aumatic event, the Manager aumatic event, the Manager aumatic event, the Manager aumatic event, the Manager aumatic event, the Manager aumatic event, the Manager aumatic event, the Manager aumatic event, the Manager aumatic event, the Manager aumatic event, the Manager aumatic event, the Manager aumatic event, the Manager aumatic event, the Manager aumatic event even	0	Rosario Vinci						Gugliuz			
<u>a</u>	2 sho		19a. Informant's Name/Relationship (Typ				,	et and Number or Ru				
2	and lealth m 27		Louis Martin, Sr./	Step-Son				e Rd., Sev	zerna Pa Date		Marylan ation - City or	
or o	Peges 1 nent of H int: if Ite		20a. Method of Disposition 1 🖰 Burial 2 ☐ Cremation 3 ☐ Re	emovaf from State		Place of Dispositi emetery, cremat		1 IIII C	h 13,			
Baltimore, Maryland 21215-0036	t. Pe timen tant: jury		4 Donation 5 Other (Specify)	. 0	Me	adowrid	-		2006			Maryland
Bal	permit. Peges 1 and 2 should by Department of Health and Menta Important: if Item 27 Is marked any Injury or other traumatic evans.		21. Signature of Funeral Service License	**		Kir	kley-R	dress of Facility uddick Fur Hwy., S.E	eral Ho	ome, I	P.A. WD	21061
			23a, Part1. Enter the disease, or complic	cations that caused	the deat						ile, MD	Approximate
			shock, or heart failure. List only on Immediate Cause (Final	e cause on each fi	ne.	in bollot dillot			7			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Clen	a	myoc	ade	el infa	retion			
	Examiner			Due to (or as	a conseq	uerice or).			. 1			
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	uence of):	period.	many -	eller			
V	uted d ansit	Examiner	Cause, Enter Underlying Cause (Disease or injury that initiated events	den	6	reac	1	releus				
ć	execut on and rial-trar		resulting in death) Last	Due to (or as	a conseq	uence of):						
8760,	ate be executed physicien and the burial-transit	dicai										
9	tifica ng ph as th	Jed	(F. F.)									
Вох	eath certific attending p	an/	23b. was decedent pregnant	3c. If yes, outcome 1 ☐ Live birth			ctopic pregna	ncy		2	3d. Date of del Month	ivery Day Year
	e dea the att	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at 9☐Unknown	t time of d	leath 5 C	Other (specify)			Worth	Day Fear
Ρ.	that the de ed by the detached	Physician/Me	9 Unknown	taibusing to double b		udias is the use	adhina nama	aven in Rod I	23a Did	tobacco us	e contribute to	the cause of death?
Division of Vital Records, P.O.	Attending Physician: The law requires that the death certific r death. • ctor: After this certificate hes been signed by the attending p by the funeral director, page 2 should be detached for use as	5	Part II. Other significant conditions con	imputing to death b	idi not res	diling in the drid	enying cause	given in Fait i.				obably 4 Dunknown
o o	requi	Completed										
ec	e law	g							24a. Wa auto	s an opsy formed?	prior to death?	itopsy findings available completion of cause of
<u> </u>	: The								1 ☐ Yes			2□ No
Vit.	ician certifi ector	Be	25. Was case referred to medical examiner?	lospital:				26. Pface of Dea				
o	Phys this	2	1 ☐ Yes 2 ☐ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	1 Lanpatie		ER/Outpatient 28b. Time of	3 DOX	- Indising i	lome 5 ☐ Res			Cify)
e G	ding h. After fune	to	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	y Year)	Injury		njuryat Work? I∐Yes 2∐No		, ,		
isi	deat deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Pface of In	ury - At h	ome, farm, stree	it, factory, offi	ce				ural Route Number,
Ō	after after Dire	Certification:	4 Homicide	building, et	tc. (Specil	ry)			City or Te	own, State)		
	spite hours neral		29a. Certifier 1 Certifying Phys	sician: To the best	of my kno	owledge, death o	occurred at th	e time, date and place	, and due to the	e cause(s)	and manner as	stated.
	To the Hospital or Attending Physician: The law requires tha within 24 hours after death. To the Funeral Director: After this certificete hes been signed completely filled in by the funeral director, page 2 should be de	Medical	(Check only 2 Medical Examinations)	ner: On the basis of and manner st	ated.	ation and/or inve	stigation, in m	ny opinion, death occu	irrea at the time			
	To the To the Comp	Ž	29b. Signature and title of certifier				29c. Lic	ense number		29d. Date	e signed (Mont	h, Day, Year)
			1 Comment	Een			DO	901414	>	Mar	ch 9	2006
	1.		30. Name and address of person who co	· 0		п 23a) (Туре, Рг	rint)	C -1	2		7	2006 Mie MO 2106
	V		31. Date filed (Month, Day, Year)	,	305	Hospi	tal D	- Juite	205	6/e	in 15vo	MIL MO
	Sta	ate	51. Date med (Month, Day, Tear)	32. Registi	ai soigna	-						100

DHMH 17 Rev 1/2001

ORIGINAL

			, rui	artment of Health and Mental Hygiene ertificate of Death
	Physicia	an	1. Decedent's Name (First, Middle, Last) MADCE M. WATTS	2. Date of Death Month Day Year MARCH 12:55A M
	/Medio		4a. Facility Name (If not institution, give street and number)	MARCH 16 2006 12:55A M 4b. City, Town, or Location of Death 4c. County of Death
	Examin	eı	916 Sunnybrook Dr	Glen Burnie Anne Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Davs Hours Min. (Month, Day, Year) Country)
	Director		Usual Residence of Decedent	July 14,1923 KY
	yland		10a. State 10b. County 10c. City, Town or L	ocation 10d. Inside City Limits
	e Mar ta-f sl	ctor	MD Anne Arundel Glen Burn	ie 1□Yes 2XXNo
	with th	Dire	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
	eath v	erai	916 Sunnybrook Dr 11. Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Specify Yes or No-
ယ	or Iten	Fun	1 Never Married 2 Married 1 Yes 3€ No If Yes, Give	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc.
93	72 hours after death with the Maryland naturel; or Items 23e or 28e-f show sical Examirer must be neilified at	d by	3 Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes ¾ No Specify: White
15-(n 72 h	Completed by Funeral Director	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	adent's Usual Occupation 16b. Kind of Business/Industry 8 kind of work done during most of working DO NOT use retired)
12	e filed within al Hygiene. other then other, ine Max	omo	Elementary/Secondary (0-12) College (1-4or 5+)	Beautician Owner Shop
b	e filed Il Hygi other vent, Il	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
ylar	2 should be and Mental Is marked o	To	Robert McGuire	Zorra F. Burnett
Maryland 21215-0036	12 sho h and 7 Is m rreum			ing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sunnybrook Dr, Glen Burnie, MD 21060
e G	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene 1 the Marylan Item 27 Is marked other then "neturel", or Items 23s or 28s-f show other treumstic event. In Madical Examiner must be notified at		201.51	obsition (Name of smallory or other place) Date 20c. Location - City or Town, State
ō	Pagas ent of nt: If If		1 Burial 2 □ Cremation 3 □ Removal from State 1 Donation 5 □ Other (Specify) 1 Donation 5 □ Other (Specify)	
Baltimore,	permit. Pagas 1 and 2 Department of Health s Importent; If Item 27 Is any injury or other tre once.		21. Signature AF neral Service Licensee	22. Name and Address of Facility
8	8958		K. STEGOLY FIRK M01140 23a. Part 1. Enter the disease, or complications that caused the death. Do not en	Tink Funeral Home, Gr.A. Burnie, MD 21061
8760,	zate be executed hysician and hysician and the buriat-transit the buriat-transit	licai Examiner	shock, or heart fatters. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, 1 any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	ULCERS OSTEOMYELITUS Interval Between Onset and Death
.O. Box 6	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medi		□Ectopic pregnancy 23d. Date of delivery □ Other (specify) Month Day Year
Vital Records, P	es be	Completed by PI	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
000	e law requir has been si ge 2 should	piet	OSTEONRTH 121 TIS	24a. Was an autopsy autopsy findings available prior to completion of cause of
E B	Th ate pag	Com	HOME HOSPICE	performed? death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
Vita	Physicien; Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)
of	Phys rr this aral dir	: To	27. Manner of Death 28a. Date of Injury 28b. Time	The state of the s
lon	Attending In death.	atior	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	Hospital of the control of the contr	Ce	29a. Certifier Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the Hospital or Ai within 24 hours after of To the Funerel Direc completely filled in by	edicai	(Chack only one) 2 Medical Examiner: On the basis of examination and/or and manner stated	nvestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
0	To the within 2 To the complet	Me	29b. Signature and Me of certifier	29c. License number 29d. Date signed (Month, Day, Year)
	15		I lebad 21	DO2519 MARCH 17 2006
	10		30. Name and address of person who completed cause of death (Item 23a) (Type RICHARD EFISHER MD	CRAIN TOWERS GLEN BURNIE MIZ 2106)
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	w

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1340 Williams 2006 14 Emma March Geraldine /Medical 4c. County of Death N/A 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore 3000 Reisterstown Road #3G If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 219-52-3703 1 □ M 2 ₽ F Yrs. 57 Director 1949Maryland Jan. 16, Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State rithen "natural", or Iteme 23a or 28a-f ehow The Medical Examiner must be notified at Baltimore Yes 2 No N/A Directo Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3000 Reisterstown Road USA 21215 filed within 72 hours after deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Ridgeway Maner Elementary/Secondary (0-12) College (1-4or 5+) Nursing Home Housekeeping 12th Hygie other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be fill iment of Heelth and Mental H tant: If Item 27 Is marked oth Annie Vaughn Musell William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 19a. Informant's Name/Relationship (Type, Print) 3000 Reisterstown Rd apt # 1k Baltimore MD Carolyn Daniels / sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 5 1 Surial 2 Cremation 3 Removal from State Department of Important: If any injury or once. Saints Rest Cemetery 3/20/06 Hanover MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of up ral Service Licenses 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 Alexin Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart fature. List only one cause on each line. Approximate Interval Between Onset and Death shock Immediate Cause (Pinal disease or condition resulting in death) **Physician** MYPERTENSIVE CAMPIONASCULAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitel or Attending Physician: The law requires thet the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Completed by Physician/Medical be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 4 Pregnant at time of death Records, P.O. 9 Unknown 9 TUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 DNO Division of Vital funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No To the Hospitel or Attendi within 24 hours after death. To the Funerel Director; A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0059107 03 16 M.D 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Uma LIBERTY NEVERTS 2600 BALTIMORS AVENUE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 7 2006 Registrar

Ashley Wetzel Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend items 23a, 27 per me 9853 3-30-06 vt. State of Maryland 7 Department of Health and Mental Hygiene 06-01706 MLM Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician** Year Ashley M. Wetzel 9 2006 March 0918 /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Baltimore n/a 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 3/19/1984 Birthplace (State or Foreign Country) **Funeral** Days Hours 213-06-5882 Months 1 M 3 TYF 21 Yrs. Director MD Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Mode MD Director Baltimore Middle River 1 Tes AND 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ma 23a or 3528 Bay Drive 21220 USA Funeral Rama 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Bace - American Indian. Black, White, etc. he Medical Examine filed within 72 hours after 1 ☐ Yes 2 **XX**o If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2XXVo Specify: à white 3 ☐ Widowed 4 ☐ Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiane. Unk. Unk. 11 0 marked other evant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dwight R. Wetzel, Jr. Laura Banknell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hilda Schwartz / Grandmother 83 Valley Bottom Rd, Aberdeen MD item 27 other tra 21001 20b. Place of Disposition (Name of cometery, crematory or other place)
Cedar Hill Cem. 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o ¥2 Surial 2 ☐ Cremation 3 ☐ Removal from State 3/14/2006 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Bacterial myocarditis complicating endocarditis /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of). Examine physicien and the burial-transit The law requires that the deeth certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical attending physic I for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Tyes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1/2 Yes 2□ No autopsy performed? 2 🗆 No 2 No Yes Attanding Physician: funeral director 25. Was case referred to medical 26. Place of Death (Check examiner? Yes 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Medical Certification; To 2☐ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending death. 2 Accident investigation 1 Tes 2 No the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide ö

efter death within 24 hours eft To the Funeral D completely filled in Hospitel To the

> State Registrar

31. Date filed (Month, Day, Year)

60

re and title of certific

29a. Certifier (Check only

29b. Signal

32. B gistrar's Signature

and manner stated.

111 Penn Street Baltimore, Maryland 21201 Specific 5

of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

OCME

29d. Date signed (Month, Day, Year)

March, 10, 2006

				State of Marylan						•		_	Jie.		
		•	1 - For State Registrar	State of Marylan			te of E		MGI	•	Reg. No	00		nglag	
			Decedent's Name (First, Middle, Last)							Date of Dea	ath	7.40	V	3. Time of Death	1
	Physici /Medio		HARRIETT	E.	WI	EISB	ERG			RCH	14		006	7:58 P M	ı
di.	Examir		4a. Facility Name (If not institution, give st					Location of Deatl	מ		4c.	County			
1			3031 FALLSTAFF RO		to a to interest of		ALTIMO	RE If Under 24 Hrs.		Data of Dia			N/A		_
	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs.	last birthday) Yrs.	Month	er 1 Year s Days	Hours Min.	n.	Date of Birt	r 495		9. Birthp	lace (State or Foreign try) MD	n
			Usual Residence of Decedent	X 00		1				17 207 .	1320	l			
	how how	L	10a. State 10b. County		y, Town or Lo								1	0d. Inside City Limits	
	88-1 c	Sct 0		/A B/	ALTIMO						15 5			1 Yes 2 No	_
	a or 2	吉	3031 FALLSTAFF RO	ND #604_C		10f. 2	21209 21209)			10g. Cit	izen of W	hat Cour U.S.		
:	within 72 hours atter death with the Maryland ene. Then "naturel", or items 23a or 28a-f ehow "a Medical Examinar must be notified at	Funeral Director		2. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Dec		spanic Origin? (S n, Mexican, Puert	pecify	Yes or No			- Americ	an Indian,	_
9	or iter	F	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give			ecify Cubar		o Rica	an, etc.)		Black	k, White WHI	TE	
003	irei', c	d by	3 Widowed 4 Divorced	Year or Dates:		T Tes	21 NO	Specify:				Specify.			
15	"nate	lete	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece	dent's Us	ual Occupa vork done d	tion uring most of wor	rking		16b. K	ind of Bu	siness/Inc	dustry	
21215-0036	within	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1		ESIDE			F	RETA	IL F	URNI	TURE	
	be filed within 72 hours after death with the Marylan be filed within 1/2 hours after 1/2 hour solution then "naturel," or items 23a or 28a-f ehow event, the Medical Examinat must be rediffed at	BeC	17. Father's Name (First, Middle, Last)		,			18. Mother's Nar					e)		
/lar	should be t and Mental I marked or umatic eve	To E	JACK		KAP	LAN		BLANCH	E				LAN	1PE	
	and lema	0.4	19a. Informant's Name/Relationship (Typ	•		-		nd Number or Ru							
	s 1 and 2 should f Health and Mer itam 27 ie marke other traumatic		SEYMOUR WEISBERG / 20a. Method of Disposition	HUSBAND	Place of Diene	eition (A	ama of	F ROAD #	604 Date					1D 21209 wn, State	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if Itam 27 ii eny injury or other tra		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	emetery, crei	matory o	other place	03/1					RE, N		
If i	artme ortani injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses			AMUN			•	115				INC.	_
Ba	Departr Departr Imports eny inje		1 Routs	7-										MD 21208	
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the deat	h. Do not ent	ter the m	ode of dying	, such as cardiad	or re	spiratory ar	rrest,			Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	Respirat	-0 A-7 0	arr-	ent							Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):										
		-	Sequentially list conditions, b.	Suptices Due to lor as a consequence	uence of			-							
'W	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										1		
o ·	ate be executed nysician and he burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):										
3760,	ate be hysicii he bu	Icai	d.												
× 68	leath certificate attending phy I for use as the	Physician/Med	IF FEMALE:												
Вох	attend for us	lan	in the past 12 months?	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3	Ectopic Other	pregnancy					23d. Date Mor	e of delive ath	ny Day Year	
P.O.	by the trached	yslc	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	iodii 5	_ O(1161 (specify/								
Q	ures that signed b d be deta		Part II. Other significant conditions cont	nbuting to death but not res	ulting in the u	nderlying	cause give	n in Part I.		23e. Did to	obacco i	ise contr	ibute to th	e cause of death?	
Records,	w require been sig should b	Completed by	s-yntic hop,							1 🗆 1	Yes 2	1 100	3 Prob	ably 4 □Unknown	1
ecc	elawr hasbe je 2sh	pie	Merid for.	lation						24a. Was autop	Sy	24b. V	Vere auto	psy findings available	а
<u> </u>	cete h	S									rmed?	d	leath?		
Vita	certifi ector	Be	25. Was case referred to medical examiner?	ospital:			Othe	26. Place of Dea							_
0	Phys raldii	. To	1 Yes 2 No	1 Inpatient 2	ER/Outpatier 28b. Time o		707	4 🗀 Nul Silig F		5 Resid				<i>'</i>)	
on .	th. : Afte	tior	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	М	28c. Injury Work 1 🗆 Y	? ′es 2 ☐ No				,			
Division of Vital	Attends ar death. ector: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, sti	reet, fact	ory, office		28f.	Location (S City or Tox	Street ar	d Numbe	er or Rura	l Route Number,	_
	Hospital or Atlanding Physician: The law requires that the death certificate 44 hours after death. Ever the control of the attending phy Funeral Director: After this certificate has been signed by the attending phy telly filled in by the funeral director, page 2 should be detached for use as the														
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examin	cien: To the best of my known: On the basis of examina	owledge, deat ition and/or in	h occurre vestigati	ed at the tim on, in my op	e, date and place inion, death occu	e, and urred a	due to the at the time,	cause(s date and	and mai d place, a	nner as si ind due to	ated. the cause(s)	
:	To the within 2 To the complei	Med	29b. Signature and attle of certifier	and manner stated.		2	9c. License	number			29d. Da	te signed	(Month,	Day, Year)	
	⊢ ≱ ⊢ ŏ		\rightarrow / λ / λ				Di	9914				115			
	1		30. Name and atteress of person who co	pleted cause of death (Iter	n 23a) (Type,	Print)						,,,	1 - 6		
_	(15		IraT. Fine Mo	10757 Falls				11-e M.	d	210%	?				_
	Sta Registi		31. Date filed (Month, Day, Year) MAD 1 7 20	32. Registrar's Signa	ature d	02164	1								

CPM06-01738 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Josephine Young Unpend item# 23a, 27 perme (853, 3/30/06 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death March **Physician** 10° 2006 17:50 Josephine /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 229 North Mount Street Apartment 311 Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 👿 F 579-62-441 Yrs. Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic avant, the Mydical Exeminer must be notified at Baltimore 1 **S**#es 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? apt ö 21223 U.S.A. 229 Items 23a 311 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M/No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Itam 27 Is marked other then "natural", or Ite 1 ☐ Never Married 2 👿 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) dm.n.strator 12 120VEYAMEN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname B. Jen Edward 19a. Informant's Name/ elationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) busband one 20a. Method of Disposition Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State Depertment of H Important: If Its any injury or of once. cemetery, crematory or other place 1 ☐ Burial 2 ☑ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3 Greenmount Crematory 21. Signature of Funeral Service Licensee auton Dalo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Fatty liver and developing liver cirrhosis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine physicien and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760, Physician/Medical attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□ Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Ves 2 □ No 24a. Was an s certificete has blirector, page 2 s autopsy performed? 1 Yes 2□No erel Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence State (Specify) 1 XYes 2 🗌 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA SCENE 27. Manner of Death 1 ANatural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital o within 24 hours aft To the Funerel Di completely filled in 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 11, 2006 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE MIKA 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Month M ATH Limmen 6 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Park Ville MD .

If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Paws Hours Min. 7-1-7, 23.19 Erickson Betierment Kalto more e Comm. 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Months Yrs. Director July 23.1918 Yugoslavia 350-28-3581
Usual Residence of Decedent 87 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 🗖 No Director Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? United States
14. Race - American Indian,
Black, White, etc. Funerai 21234 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married ō 1 ☐ Yes 2 🙀 No by Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Carpenter Carpentry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Josef Zimmermann Juliane Kenjeresch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum <u>once.</u> 19a, Informant's Name/Relationship (Type, Print) Theresa Lawler, Daughter 17 Gray Squirrell Court, Timonium, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ☑ Other (Specify) Enternment Timonium, Maryland Dulaney Valley Memorial Cohs. 3/18/06 21. Signature of Fundal Service Livensee 22. Name and Address of Facility Brian T. Chisholm Funeral Services of Dulaney Valley, P.A. 200 Padonia Road, Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to or as a consequence of) Examiner Mem flany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and Due to (or as a consequence of) sician a burial-1 Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Vital 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 2 No 1 🗌 Yes 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 4 hours after death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 20 within 24 hours a To the Funeral C 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

31. Date filed (Month, Day, Year)

29b. Signalue and title of certifie

30/19 me and address of gerson who completed cause of death (Item 23) (Type, Print) Sruce Bummtha 32. Registrar's Signature

29d. Date signed (Month, Day, Year) 116

Sarka Zabkova Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend items 16a, b per fh e853 3-24-06 vt.
Unpend item# 23a-b, 27, pende, 32, 27 06-01852 d11 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Sarka Zabkova 2006 March 13 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□ M 2QF 50 Director 1955 Czech Republic Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ---- any injury or other traumatic average. 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location M Yes 2 No Baltimore Directo Maryland 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number Czech Republic 21224 Completed by Funeral 338 El Rino Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry
Own Home 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic - Housekeeping 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ၉ <u>Jaroslav Vondra</u> Vera Hueberova 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 338 El Rino Street Baltimore, MD 21224 Petr Zabek- Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/17/2006 Catonsville, MD Metro Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Charles S. Zeiler & Son, Inc. addite 6224 Eastern Avenue Baltimore, MD 21224 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac arrhythmia Physician /Medical Due to (or as a consequence of): Examiner Mitral valve prolapse and cardiomegaly Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner ettending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) been signed by the c should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 🛱 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? certificete 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 XYes 2 No 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🖾 Natural 5 Pending investigation м 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Needical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

eral Director: After thi thin 24 hours e

Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number mi's OCME March 16, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LING 111 Penn Street, Baltimre, Maruland 21201 LI 31. Date filed (Month, Day, Year) 3 Registrar's Signature State 7 2006 Marie J.

٥

(Check only one)

Year

			For 1 State	• •			Depa	artment	t of H	ealth a		lental Hy		_	001	0.0
			Registrar	- (a - 4)			Cer	tificate	e of L	Death		2. Date of De	Reg. No.	UUb	3. Time of	9 9
	Physicia		Decedent's Name (First, Middle Carroll	E.		Arms	stron	g				Month 03	3 Pay	200	ar	
	/Medic Examin		4a. Facility Name (If not institution					4b. City, 7		Location o	of Death		4c.	County of D	eath	
	-		Devlin Manor N 5. Social Security Number	ursing H		In yrs. last b	irthday)	Cum If Under	1 Year	and If Under:	24 Hrs.	8. Date of Bir	th		Birthplace (State or	r Foreian
	Funeral Director		220-18-1812	1 € M 2 □			Yrs.	Months	Days	Hours	Min.	J\dn"28	r, 492	25	CONVID	
1	and t		Usual Residence of Decedent 10a, State 10b, County		11	Oc. City, To	wn or Lo	cation							10d. Inside Cit	y Limits
	e-feh	ctor	MD Alle	gany		C	umb	erlan	a 	_					1X Yes	2 🗆 No
1	within /2 hours after death with the Maryland ene. Hen "natural", or iteme 23e or 28e-f ehow the Maidical Examiner must be notified at	Funeral Director	10e. Street and Number 11626 Eagle Av	enue SV	N			10f. Zip		21502	2		10g. Citi	izen of What	Country?	
1	me 23	nera	11. Marital Status	12. Was I	Decedent Eve d Forces?	er in U.S.	13. \	Was Deced	ent of Hi	spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	-	14. Race - A	merican Indian,	
S .	s arter , or ite	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	ied 1√2 Y	es 2 No	VW II		1 ☐ Yes 2	Y	Specify:	1, 7 46110	riouri, otc./		Specify: M		
2002-0	atural cal Ex	ted b	15. Deceden	's Education		16	a. Deced	dent's Usua	l Occupa	ation	t of work	na	16b. Ki	ind of Busine	ess/Industry	
7	hen "n	Completed	(Specify only highe Elementary/Secondary (0-12)		ge (1-4or 5+)	ele	ite. L	kind of wor DO NOT us Cian	e retired,	iuring mosi)	t or worki	ng	Stat	e of M	aryland	
7	Hygie other t	Be Co	17. Father's Name (First, Middle,			Oic		J.C.11		18. Mothe	r's Name	(First, Middle	Maiden	Sumame)		
yland	should be filed within and Mental Hygiene. E marked other then " umatic event, the Mac	To B	Carroll E. Arr									Arms				
Mar	od 2 sho		19a. Informant's Name/Relations Barbara Snyde	hip <i>(Type, Print)</i>	daugh	ter 19	h Mailin	f2 Bay	yber yber	ry Ave	ë°SW	^{y Po} Cumi	beria	nd Stat	MD ^c 型150:	2
more,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelith and Mental Hygiene. Department of Heelith and Mental Hygiene. Importanti if them 27 is marked other then "natural", or iteme 23a or 28e-1 ehow eny injury or other traumatic event, the Madical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S			20b. Place Sunset	of Dispo enveren Men	sition (Nam natory or a norial F	ne of ther place ark	e)		ate 3/13/2006		mberla	or Town, State and M	D
Dairimo	permit. Departm Imports eny inju		21. Signature of Funeral Service	Licensee	aia	all-	22					me, PA : Cumbe	rland,	MD 21	502	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications the	nat caused th on each line.	e death. Do	not ent	er the mode	e of dying	g, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Bety Onset and D	reen
F	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		estate		Colon	Co	7v-					unlaror	
E	Examiner		Commentative first area statement	5	to (or as a c	consequence	e orj.									
A 3	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due	to (or as a c	consequence	e of):									
,	te be executed ysicien and e burial-transit	Examiner	that initiated events resulting in death) Last	c	to (or as a c	consequence	e ol):									
	ate be hysicie the bur	ical		d												
SO XO	certifica Iding ph	/Med	IF FEMALE:	23c. If yes	, outcome of	pregnancy								23d. Date of	delivery	
	Geath e atter	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 □ L 4 □ P	ive birth 2 [regnant at tin	☐ Fetal deal		Ectopic pro Other (spe						Month		'ear
ר כ	requires that the een signed by th hould be detache		9 Unknown Part II. Dther significant conditi			not resulting	in the ur	ndertving ca	ause dive	en in Part I.		23e. Did 1	obacco i	use contribut	e to the cause of de	eath?
g,	w requires that been signed t should be det	ed by	levir forliere	1				, ,				10	Yes 2	□No 3 □	Probably 4 🗆 U	nknown
ည က	aw Bst 2 s	Completed	/	,								24a. Was	DSV	24b. Were	autopsy findings a to completion of ca	available ause of
ב ;	sicion: The law s certificete hes t lirector, page 2 s			-								perfo 1 ☐ Yes	rmed? 2 → No	deat	h? Yes 2□ No	
N I I I	Physicien: rthis certific ral director,	To Be	25. Was case referred to medica examiner? 1 Yes 2 No	Hospital:	I 🗍 Inpatient	2 🗆 ER/O	Outpatien	nt 3 DO	A Othe	0.00		n <i>(Check</i> on <i>ly i</i> me 5 ☐ Resi		6 □Other /	Specify)	
	Jing Phys		27. Manner of Death 1 ☑Natural 5 ☐ Pendir	28a. C	ate of Injury Month, Day Y	28b	. Time of Injury	21	8c. Injury Work	at		28d. Describe			-, -,,	
JIVISION	Attending r death. ector: After by the fune	licati	2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	gation not be	lace of Injury	r - At home.	farm, str	M eet factory		Yes 2 🗆		28f. Location (Street an	d Number o	r Rural Route Numi	ber.
=	s effer s effer et Dire ed in by	Certification;	4 Homicide determ		uilding, etc.			551, 1 4 5157	, 000			City or To				
:	To the Hospital or Attanding Prysticien: The within 24 Hours eiter death. To the Funarel Director: After this certificate hi completely filled in by the funeral director, page	edicai	29a. Certifier 1 Certifyin (Check only 2 Medical	ig Physician: To Examiner: On the and	the best of in the basis of ex manner state	xamination a	ge, death and/or inv	n occurred a vestigation,	at the tim in my or	ne, date an pinion, dea	nd place, ith occurr	and due to the ed at the time,	cause(s)	and manne place, and	r as stated. due to the cause(s)	
;	To the within 2 To the complet	Me	29b. Signature and title of certifie	10						number			- 1		Ionth, Day, Year)	
			> Syst	lin					DO	0175	65		15	10,	7000	
	5		30. Name and address of person	OLLIN(Cause of deal	in (item 23a) (Type,		NA	DOW	n_ +	twy. L	AVA	LE, A	ND AIS	02
	Sta		31. Date filed (Month, Day, Year,		2. Registrar's	s Signature		e 49	4							
	Registr	ar	MAR 1	o ZUUb	Masua	a St.	A.	TO CELL	P					~		

			For State	State of M	larylan	-	artment rtificate			nd Mer	-		006	08200
	ch J		Registrar 1. Decedent's Name (First, Middle	9. Last)		00	uncate	OID	Calli	2.	Date of Dea	Reg. No. ath	40.00	3. Time of Death
×	Physici			EMBURY							Month	Day		6 11:07A ^M
R.	/Medic Examin		4a. Facility Name (If not institution)		4b. City, T	Town, or L	ocation of [DEGG		County of Dea	
			Prince George	es Hospita	l Ce	enter	C	heve	rly			Pr	ince G	eorges
	Funeral		5. Social Security Number	6. Sex 7. Ag		last birthday)			f Under 24 Hours	Hrs. 8. Min.	Date of Birt (Month, Day ct.20	h y, Year)	9. Bir	thplace (State or Foreign
	Director	y I	267-22-9531 Usual Residence of Decedent			83 Yrs.				00	ct.20	, 1	922 0	A
	land ow		10a. Sfate 10b. County		10c. Cit	y, Town or Lo	cation						_	10d. Inside City Limits
	Many Feb	tor	Md. PG			Capi	tal H	le i ah	nts					M∑Yes 2 No
	or 28g	Director	10e. Street and Number			- Cupi	10f. Zip (10g. Citi	zen of Whal Co	ountry?
	23a (23a)		1207 Addison	Rd. #325				207	743			Uni	ted St	ates
	r dea	Funerai	11. Marital Status	12. Was Decedent Armed Forces	Ever in U	.S. 13.	Was Decede	ent of Hisp fy Cuban,	anic Origin Mexican, F	n? (Specify Puerto Ric	Yes or No- an, etc.)	-	14. Race - Ame Black, Whit	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ied 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No		1 ☐ Yes 2		Specify:			1	Specify:	
S S	tural	ed b	15. Decedent			16a. Dece	dent's Usual	I Occupation	on		1	16b. Kir	B1	ack
21215-0036	within 72 hours after death with the Maryland one. Then "natural", or Items 23s or 28s-f show fre Modical Exercition round be notified at	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4or	5.)	(Give	kind of work DO NOT use	k done dur	ing most of	of working				
21	giene er the	Com	12	College (1-40)	J+/	Rest	aura	nt O	wner			Pri	ivate	
	al Hygie d other	Be (17. Father's Name (First, Middle,	Last)				11	8. Mother's	s Name (F	irst, Middle,	Maiden	Surname)	
<u>yla</u>	2 should be and Mental is marked o aumatic eve	2	Joshua Hill						Oliv		John			
Maryland			19a. Informant's Name/Relations!			1041	1 Eld	ders	Hol	low	Drive	-	Town, State, a	Zip Code)
	1 and Health em 27 other tr		Carol Banks/1	niece	20b. P	Mito Place of Dispo cemetery, crer	heII	vill	e, M	d2	0721		cation - City or	Town, State
nor	Pages nent of int: if it		1			emetery, crer Surre					- 1		nton,	
altimore,	글 된 본 글 .		21. Signature of Funeral Service I		i i e		2. Name and		- '				dwards	
ñ	Depa Impo any is		Aniso)	Ellura	1	1								,Md.20746
100	. A		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	d the deat									Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Acute		nardi.	1 Tn	f						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as			1.1LII	rarc	CLON					Sudden
	Lxammer	L.	Sequentially list conditions, if any, leading to immediate	b										
T	nsit	nine	cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	uence or):								
	execu n and al-tra	Examiner	that initiated events resulting in death) Last	c Due to (or as	a conseq	uence of):								
8760,	certificate be executed iding physicien and ise as the burial-transit	cail		d	•									
Ö	tificat ng phy as th	ledi	15 55144 5	1										
Вох	leath certific attending p	an/N	IF FEMALE: 23b. Was decedent pragnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pre	onancy				2	3d. Dale of del	,
	at the dea by the at tached fo	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐★No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of d	eath 5	Other (spe	city)					Month	Day Year
0	that the ed by detacl		Part II. Other significant condition	ens contributing to death I	out not res	ulting in the u	nderlying ca	use given	in Part I		23e. Did to	obacco u	se contribute to	the cause of death?
ecords,	law requires that the death as been signed by the atter 2 should be detached for u	d by	Senile Demer			-	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	g				es 25		obably 4 []Unknown
Ö	w req	Completed		1010							24a. Was a	an	24h Were au	rtopsy findings available
Ä	The la	рша					- 				autop perfor	sy med?	prior to death?	completion of cause of
Vital R		0	25. Was case referred to medical					2	6. Place of	f Death (C	1 ☐ Yes heck only o	2 <u>12</u> No ne)	1 🗆 Yes	3 € No
	A .24 U	To B	examiner? 1 ☐ Yes 2 ☐ x No	Hospital:	ent 2 🔯	ER/Outpatien	it 3 DOA	Othor					Other (Spe	cify)
0	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	ıry ıy Ye <i>ar)</i>	28b. Time of Injury	28	Bc. Injury at Work?	t	28d	. Describe h	ow injury	occurred	
<u> </u>	Attendia death. ctor: A y the fu	catl	2 Accident investig	pation			М		s 2 No					
Division of	af or Attend after death I Director: d in by the f	Certification:	4 Homicide determi	ined 28e. Place of In building, e	jury - At ho tc. (Specify	ome, tarm, str y)	eet, factory,	office		281.	City or Tow	itreet and m, State)	d Number or Ru	ural Route Number,
	Hospital 14 hours a Funeral I tely filled		29a. Certifier 1 T Certifying	g Physician: To the best	of my kno	wledge, death	n occurred a	it the time.	date and p	place, and	due to the o	cause(s)	and manner as	stated
	P Full	Medical	(Check only 2 Medical I	Examiner: On the basis of and manner st	of examina	tion and/or in	vestigation, i	in my opin	ion, death	occurred a	at the time, o	date and	place, and due	to the cause(s)
	To the Hospital within 24 hours a To the Funeral C completely filled in	ž	29b. Signature and title of certifier	. 11)	29c.	License n	umber	0	-	29d. Date	signed (Mont	h, Day, Year)
			I les yls	ullen	_/			VZ	4	00		2	-27-	2006
	3		30. Name and address of person v	who completed cause of	death (Item	1 23а) (Туре,	Print)		۲.	0	1 /	1 (6 40	2.220
1886		• 0	Seter M Scl 31. Date filed (Month, Day, Year)	hister mo	rar's Signa	00 G4	cenu	vay	S	W.	Hee	nbel	nima	2006 2017 2077
*	Sta Registr			2006 Me	A A	Los	el s	/						

		•	1 - State of Ma		epartment of H Certificate of L			giene () () () () () () ()	08201
			Decedent's Name (First, Middle, Last)	-			2. Date of De		3. Time of Death
	Physicia /Medic		Sterling Geo	orge Bro	wn		March	8 2006	
	Examin		4a. Facility Name (If not institution, give street and number)		,	Location of Death		4c. County of Dea	ath
			71 Maloney Road 5. Social Security Number 6. Sex 7. Age	a (In yrs. last birti	Elkton	If Under 24 Hrs.	8. Date of Birt	Cecil	rthplace (State or Foreign
	Funeral Director		218-01-9453 ¹ ∑™ ² □F 86	y, Year)	aryland				
	pui 🛊		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	daryla f sho	ō	Maryland Cecil	E1kto					1 ☐ Yes 2 X No
	r 28a-	Directo	10e. Street and Number	LIKCO	10f. Zip Code			10g. Citizen of What C	Country?
	th with		71 Maloney Road		21921			United S	tates
	tams	Funeral	11. Marital Status 12. Was Decedent 8 Armed Forces?	Ever in U.S. World	13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race - Am Black, Wh	
36	irs afte	by F	1 Never Married 2 Married 11 Y Yes 2 N 11 Yes, Give 1 Year or Dates:	war II	1 ☐ Yes 2 📜 No	Specify:		Specify:	hite
Maryland 21215-0036	a within 72 hours after death with the Maryland piene. r than "natural", or Itams 23e or 28e-f show the Medical Evarinet nast be trutified at		15. Decedent's Education (Specify only highest grade completed)	16a.	Decedent's Usual Occupa (Give kind of work done of	ation	ina	16b. Kind of Busines	· · · · · · · · · · · · · · · · · · ·
21	rithin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5		life. DO NOT use retired	0	,,,,,	0	
2	e filed w Il Hygier other ti		12 17. Father's Name (First, Middle, Last)		Plumbing Ins		e (First, Middle,	Maiden Sumame)	Government
au	Mental Merkad o	To Be	Restus L. Brown				llen Je		
ar.	2 should and Men is marka aumatic	٦,	19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address (Street a				Zip Code)
	s 1 and 2 should be if Health and Menta itam 27 is markad other traumatic ex		Daniel E. Thomas/Nephew		04 West Main		-		
altimore,			20a. Method of Disposition 1 🛣 Burial 2 ☐ Cremation 3 ☐ Removal from State	1	Disposition (Name of y, crematory or other place		13,	20c. Location - City o	
<u>=</u>			* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Elkto	on Cemetery	2006		Elkton, M	aryland
Ba	permit. Departr Imports any inji		Daniel & Hick	GS	Hicks Home 103 W. Sto	for Fune ckton Str	erals, P eet, El	'.A. kton, Mary	land 21921
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir	the death. Do n			or respiratory ar	rest,	Approximate Interval/Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	~~~ z	y Can	cen			3/00
	/Medical Examiner	Ш	Due to (or as	a consequence]):				/ /
Ļ	Mary	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caeca (Disease of Agent)	a consequence of	of):				
V	scuted ind transii	Examiner	that initiated events						
60,	ficate be executed g physician and as the burial-transit	ai E	Due to (or as	a consequence o	31):				
6876 0	ficate physics the	edicai	d						
XO	death certifi e attending id for use as	M/UI	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant	of pregnancy 2 Fetal death	3 Ectopic pregnancy	,		23d. Date of d	
O. B	0 0	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Yes 2 No		5 Other (specify)			Month	Day Year
<u> </u>	The law requires that the tte has been signed by the bage 2 should be detache		Part II. Other significant conditions contributing to death b	ut not resulting in	the underlying cause give	en in Part I.	23e. Did to	obacco use contribute	to the cause of death?
Vital Records,	uires n sign	d by				71	1 🕒	res 2 □ No 3 □ F	Probably 4 Unknown
O S S	aw requir s been si 2 should I	Completed					24a. Was	an 24b. Were a	autopsy findings available completion of cause of
ž		Com					perfo	rmed? death?	s 201No
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?		Oth	26. Place of Deat			
	Phys r this ral dir	. To	1 ☐ Yes 2 ☐ No ☐ Hospital. 1 ☐ Inpatie 27. Manner eath 28a. Date of Inju	ont 2 ER/Out		4 Nuising no		dence 6 Other (Sp now injury occurred	ecity)
ion	Attending Physician: or death. actor: After this certific. by the funeral director.	ation	1 atural 5 ☐ Pending (Month, Day 2 ☐ Accident investigation		njury Wor	k? Yes 2 □ No			
Division of		ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inju- building, et	ury - At home, far c. (Specify)	rm, street, factory, office		28f. Location (S City or Tox	Street and Number or I vn, State)	Rural Route Number,
	spital or ours afte naral Dir filled in	O			4-1	<u> </u>			- aloted
	한 수 한 후	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of the basis of and manner state.	f examination and	d/or investigation, in my o	ne, date and place, pinion, death occur	red at the time,	date and place, and di	us to the cause(s)
	To tha Hos within 24 hd To tha Fun completely	Me	29b. Signature and title of centilier		29c. Licens	e number	/	29d. Date signed (Mor	h, Day, Year)
	1		(do-)		(N)	0056	5449	3/10/	0.6
	VO	,	30 Name and address of person who completed cause of d	eath (Item 23a) ((Type, Print)	- Sit	1-20	ZIKL	MAZIAN
	Sta	te	31. Date filed (Month, Day, Year) MAR 1 7 2006	ar's Signature	houseles	ا ا	e co	- Collin	Charlet de
	Registr		MAK T (2000) TOPPER	2 55 /	Goods			, , ,	

Leslie Lee Bell 06-01360 NJM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar		State of M	larylar				ealth a Death		_	giene Reg. No	11111	0820	2
Н	Physici	an	1. Decedent's Name (First, I Leslie Le		n e11							2. Date of De Month	ath Day	y Year	3. Time of De	ath
	/Media	cal	4a. Facility Name (If not inst	····	February 23 2006 1726 4b. City, Town, or Location of Death 4c. County of Death											
j.	Examir	ier	10364 Coll			,			lumbi		J. 500			Howard	••••	
	Funeral		Social Security Number	6. Se	7. A M 2□F	ge (In yrs.	last birthday)	If Unde	r 1 Year	If Under	24 Hrs. Min.	8. Date of Bird March	th wy Year)	9. Bi	rthplace (State or Fo	oreign
	Director		215-60-9602 Usual Residence of Decede		7 M 2 U L		- Yrs.					March .	21,1	954	(unk)	
	yland 10w		10a. State 10b. Co	ounty		10c. Ci	ty, Town or Lo								10d. Inside City L	imits
	e Maria	ctor	Maryland How	vard			Columb								1 🗆 Yes 2 (XNo
	th with th	Funeral Director	10e. Street and Number 10364 College	e Squa	are			10f. Zi	p Code 21	.044			10g. Cit Un	izen of What C ited St	ountry? Cates	
920	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "natural", or iteme 23a or 28a-1 show event, the Medical Examinar must be notified at	P P	11. Marital Status 1 Never Married 2 3 Widowed 4 XOive		12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	? No				spanic Ori n, Mexican Specify:		cify Yes or No Rican, etc.)	-	14. Race - Am Black, Wh Specify:		
2-0	72 ho	eted	15. Dec (Specify only I	edent's Edu	ucation de completed)		16a. Dece	dent's Usu	al Occupa	ation during mos	t of worki	ng	16b. K	ind of Business	/Industry	
121	within ne.	Completed	Elementary/Secondary (0,		College (1-4or	5 1)	Finan			luring mos:) ner			se1	f emplo	oved	
d 2	filed with Hygiene. other ther		17. Father's Name (First, Mi	ddle, Last)			TITION	CIUI	1 101		er's Name	(First, Middle,			by Ca	
lan	should be nd Mental marked o	To Be	Leslie C. Be	L1						Wret		Jailli		,		
Maryland 21215-0036	bs 1 and 2 should to the alth and Ment Itam 27 is marked rother traumatic erother traumatic	-	19a Informant's Name/Rela Julia A. Catu	itionship (T)	ype, Print) -Executri	x	19b. Mailir 2716	ng Addres Hun	s (Street a	ib Dri	r or Rura	ork, P	er, City o	y Ivania y Ivania	Zip Code) 17402	
Baltimore,	Pages 1 and of Heisen of Heisen int: If Itam		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth			Met	Place of Disponentery, crep Cropoli	osition (Na matory or tan	me of other plac Crema	tory	3/2/	²⁰⁰⁶		cation - City of xandria	Town, State a, Virgin	ia
20a. Method of Disposition Comparison C								nald	nev ^{Addre} f	sorgwa orgwa	ardt I Roa	Funera	l Ho svil	me, PA le. Mar	yland 20	705
	Physician /Medical Examiner		23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) 5-quantiatly list conditions.	(a	s a consec	lente	er the mo	de of dying	g, such as		r respiratory ar	rrest,		Approximate Interval Betwee Onset and Dea	in th
,8760,	icate be executed physician and sthe burial-transit	dical Examiner	Sequentially lat conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	Due to (or as Due to (or as d.											
.O. Box 6	The law requires that the death certific Ite has been signed by the attending p page 2 should be detached for use as:	Physician/Med	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	11	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	al death 3	∃Ectopic p ∃Other (s						23d. Date of de Month	blivery Day Yea	r
rds, P.	w requires that been signed b should be deta	by	Part II. Other significant co	HCc	Intributing to death	but not res	sulting in the u	nderlying	cause give	en in Part I.		23e. Did to		_	o the cause of death	
of Vital Records,		Completed										1 Yes	rmed? 2 \(\text{No} \)	24b. Were a prior to de th? 1 de e	utopsy findings ava- completion of cause s 2 No	ilable e of
₹	Physician: this certific ral director,	o Be	25. Was case referred to me examiner? 1√2 Yes 2 □ No	-	Hospital:	iont 2	ER/Outpatier	nt 3□ D	OA Othe			Chack only o	-	S DOther (Ca	ecify) Scene	-
	ding h. After fune	-	27. Manner of Death	ending vestigation	28a. Date of Inj (Month, Da	ury	28b. Time of Injury		28c. Injury Work	at ? Yes 2 □ I	2	28d. Describe			Scene	
Division	al or Attend after death Director: d in by the	Certification;	3 ☐ Suicide 6 ☐ C	ould not be etermined	28e. Place of In building, e			eet, factor	y, office		2	28f. Location (S City or Tox	Street an vn, State	d Number or F	ural Route Number,	,
	To the Hospital or Al within 24 hours after of To the Funaral Direc completely filled in by	ledical C	29a. Certifier 1 Certifier (Check only one)	tifying Phy lical Exam	rsician: To the besiner: On the basis and manner s	of examina	owledge, death ation and/or in-	h occurred vestigation	at the tim	e, date and pinion, deat	d place, a	and due to the	cause(s) date and	and manner a I place, and du	s stated. e to the cause(s)	
	To the vithin 2 To the complet	Me	29b. Signature and title of co	ertifier				29	c. License	number			29d. Dat	e signed (Mon	th, Day, Year)	
	16		Theod	Lece 1	U IC	# =	an		OCM	£		F	'ebrı	arv. 2	4. 2006	
			30. Name and address of pe		1.0	death (Iter	n 23a) (Type,									
			31. Date filed (Month, Day,	NE M	32. Pilogisi	rar'e Cion	atuso 4	11	1 Per	n St	reet	Balti	more	, Mary	land 2120	1
	Sta Registr		MAR		006	and digital	B. A	SENEL.								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** Joseph Richard Boyd 0144 25 2006 Feb /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Calvert Prince Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 □ F 89 Director Maryland 212-18-3286 May 1 1916 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. toside City Limits 10b. County 10a. State 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Calvert Directo Maryland Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 221 Plum Point Road 20639 United States or items 23a e filed within 72 hours after death all Hygiene. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 GYes 2 □ No If Yes, Give Year or Dates: 33–37 Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) engineer inspector 12 stationary engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be es 1 and 2 should be fi of Health and Mental H litsm 27 is marked ot Sarah Boyd Walter Vaese 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 221 Plum Point Rd. HUntingtown, MD 20639 Mary Jo Boyd - daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
importent: if its
any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Funeral Service March 2 2006 Alexandria Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Funeral Service Licensee DKauso 4405 Brownes Is. Rd. Port Republic MD 20676 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. acite Intracionial Immediate Cause (Final disease or condition resulting in death) hours Physician /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine as the burial-transit requires that the death certificate be executed that initiated events been signed by the attending physicien and should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical tF FEMALE: 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Ves 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 - No 1 Yes if or Attending Physicien: after death. Director: After this certifice Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel within 24 hours a To the Funerel I completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P46314 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) 5-it 310 Dr mo 9 110 31. Date liled (Month, Day, Year) 32. Registrar's Signature State FEB 2 8 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2006 2:20 AM FEB Burnett Ruth Janice /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore n/a St. Agnes Hospital If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2√F Yrs. Director 57 213-54-7322 1948 Virginia Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28e-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director Baltimore n/a the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 USA 602 Chapel Gate Lane Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. real estate secretary permit. Pages 1 and 2 should be file.
Department of Health and Mental Hygis Importent: if tiem 27 is marked any injury or other the marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Cleo Hall Virginia Charles Burnett Jack ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 602 Chapel Gate Lane, Baltimore, MD Scott Trapnell Hilleary, friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State

Other (Specify) 02-27-2006 Lothian, MD 20711 James Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility William 20736 Rausch Funeral Home, P.A., Owings, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PROBABLE ASPIRATION PNEUMONIA **Physician** HOURS /Medical Examiner UPPER GASTROINTESTINAL HEMURRHAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ Month in the past 12 months? 1 ☐ Yes 2 📆 No Year Dav 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by SCHIZOPHRENIA 1 Yes 2 No 3 Probably 4 Unknown HYPOTHERMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 XYes 2 \sum No 24a. Was an autopsy performed? certificate 2□No Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No Director: After the 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel I 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D6037359 cus M. FEB 20, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVE BALTIMORE, MODIDZ9 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 4 2006 Registrar

68760

P.O.

ō R

Division

2

			For State Registrar	State of Ma	arylan	•		nt of H <i>te of L</i>		nd Me		giene Reg. No	000		08205
			Decedent's Name (First, Middle, L.	Last)						2.	Date of De.	ath	-	441	3. Time of Death
	Physici		WITTIAM HADOTE	D BUCHANAN						м	Month arch	O1	, 200	ear 6	10:00 p ^M
	/Medio Examin		4a. Facility Name (If not institution, g				4b. Cit	, Town, or	Location of		arcii		County of		10.00 p
	LAdimii	101	Hartley Hall Nur	csing Home			Poc	omoke	City			W	orces	ter	
	Funeral			. Sex 7. Ag	e (In yrs.	last birthday) If Und	er 1 Year	If Under 2	4 Hrs. 8.	Date of Birl (Month, Da	th Vanch	9	9. Birthpl	ace (State or Foreign try)
	Director		221-05-1875	1 X M 2 □ F	8	34 Yrs.	Months	Days	Hours	Min.	an. 17	7, 1	922 D	elav	vare
	p .		Usual Residence of Decedent												
	irylar phow	L.	10a. State 10b. County		10c. Cit	y, Town or L	ocation							10	od. Inside City Limits 1 ☐ Yes 2 No
	Ba-f	cto	MD Worcest	:er	Poo	comoke	Cit	Y							
	or 28	Director	10e. Street and Number				10f. Z	ip Code				10g. Cit	izen of Wh		try?
	after death with the Marylar or Items 23a or 28a-f ehow tologe mint be cotified at	rai	1826 Cedar Hall					21851					US		
	de E	Funeral	11. Marital Status	12. Was Decedent Armed Forces?			Was Dec If Yes, sp	edent of Hi ecify Cuba	spanic Origi n, Mexican,	in? (Specif Puerto Ric	y Yes or No an, etc.)	-	14. Race - Black,	White,	
9	or th	by Fi	1 Never Married 2 Married	If Yes, Give			1 🗆 Yes	2[X No	Specify:				Specify:	wh	ite
21215-0036	hour:	d b	3 XWidowed 4 □ Divorced	Year or Dates:	194		dont's Lle	uat Occupa	ation			16h K	ind of Busi		
5	"na"	Completed	15. Decedent's (Specify only highest of			(Give	a kind of v	ork done o use retired	luring most o	of working		10D. K	iria di Busi	1102241110	lustry
2	within	m d	Elementary/Secondary (0-12)	Cottege (1-4or 5	5+)	ACCOU			,			Ed	ucati	on	
N B	be filed within 72 hours after death with the Maryland all Hygiene. Ad Hygiene. Ad other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event. I'm Medical Evarul, ar must be notified at		17. Father's Name (First, Middle, La.	(st)		110000	110011		18. Mother	's Name (F	First, M iddle,				
Maryland	Mental I	o Be							Sac	T oif	aylor				
Ξ	should be nd Menta i marked umatic ev	2	John Edgar Bucha 19a, Informant's Name/Relationship			19b. Mail	ina Addre	ss (Street a			Route Numbe	er. City o	or Town. St	ate. Zip	Code)
<u>8</u>	d 2 sho th and th and treum		Janet Wigton (da	303							ke Cit			_	·
ď.	s 1 and 2 should if Health and Men item 27 is marke other treumatic		20a. Method of Disposition	rugiteer /	20b. F	lace of Disp	osition (N	ame of		Dat			ocation - C		wn, State
2			1⊠ Burial 2 ☐ Cremation 3			emetery, cre				/5/20	106	Pod	romoke	- Ci	ty, MD
Baltimore,	artme artme ortan injury		4 ☐ Donation 5 ☐ Other (Special Service Lice)		tпs	t Bapti		-				_			cy, in
Ba	permit. Pages Department of Important: If it eny injury or o		Dry 1 0 1			F	lollo	way M	elson	Fune	ral Ho	ome,	P.A.	210	051
			23a. Part1. Enter the disease, or co	omntications that caused	the deat						comoke		.У , МІ	210	Approximate
			shock, or heart failure. List on Immediate Cause (Final	nly one cause on each li	ne.						-				tnterval Between Onset and Death
).	Physician /Medical		disease or condition resulting in death)			GE P	ARKI	NSON	1/3 1	UISEA	45E				
	Examiner			Due to (or as			n.	SEASI							
		- i	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. ALZ+ Due to (or as			U	8EAS 1							
	ted	Examiner	cause. Enter Underlying Cause (Disease or injury												
	xecu and	xar	that initiated events resulting in death) Last	c. Due to (or as	a conseq	uence of):							-		
8760,	icate be executed physician and s the burial-transit			(2)											
687	cate phys	dical													
	The law requires that the death certific ite has been signed by the attending p age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregna	ancy						į	23d. Date	of delive	rv
Box	atter for u	ciar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at			□Ectopic □ Other (pregnancy s <i>pecify)</i>					Monti		Day Year
o.	the d y the ched	isi	1	9□ Unknown				-,,,							
٥.	res that the de signed by the a be detached f	P.	Part II. Other significant conditions	s contributing to death b	ut not res	ulting in the	underlying	cause give	en in Part I.		23e. Did t	obacco	use contrib	ute to th	e cause of death?
Records,	uires sign Id be	d by									1 🗆	Yes 2	No 3	☐ Prob	ably 4 Unknown
ò	w require been sig should t	Completed									24a. Was	an	24h W4	are auto	osy findings available
ĕ	The law cate has I	m								_	auto		pri	or to cor ath?	nptetion of cause of
<u>=</u>											1 ☐ Yes	2	1 [Yes	2 0
Vital	Physicien: r this certifice ral director, p	Be	25. Was case referred to medical examiner?	Hospitat:				Othe	25		Check only o				
ō	Phys this raldi	.T	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatie		ER/Outpatie 28b. Time		JUA	4 Charles		d. Describe				′)
ב	ding After fune	ţ	f Aaturat 5 ☐ Pending	(Month, Da	y Year)	Injury	М	28c. Injury Work	k? Yes 2 □ N				.,		
Division of	or Attending after death. Director: After in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not	t be	iury - At h	ome, farm, s					f. Location (Street a	nd Number	or Rum	l Route Number,
<u>></u>	aftar Dire	erti	4 Homicide determine	building, et	c. (Specif	<i>y)</i>		.,,			City or To	wn, State	9)		
	spita ours nerai	0	29a. Certifier 12 Certifying	Physician: To the best	of my kno	wledge dea	th occurre	d at the tim	ne, date and	place and	d due to the	causeis) and man	ner as st	ated.
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Ex	caminer: On the basis o and manner st	t examina	ition and/or i	nvestigati	on, in my o	pinion, death	h occurred	at the time,	date an	d place, an	d due to	the cause(s)
	To the within 2. To the complet	Z e	29b. Signature and title of certifier				2	9c. License	number			29d. Da	ite signed ((Month,	Day, Year)
	⊢ s ⊢ ŏ		Catri	M.D				000	6217	2		7	121	201	× .
			30. Name and address of person wh		leath /tter	n 23a) (Tucc	Print		1 /					-01	
-	3+1		^	SATYAL, MD		1604	MAR	ICET	ST	Pocom	OKE C	TY	MD	218	51.
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registr				,							
	Regist		MVD 0 4	2000		N =	hand	5,							

			State of Maryland / Department of Hea	alth and M	lental Hygi	ene				
a	mend it	em		eath	Re	g. No. 🕕 🕕	6	08206		
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day	Year	3. Time of Death		
	/Medic	al	lerrie Bozman		2		2006	14-40 AM		
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Lo Deer's Hend Hospital Center Souts!	cation of Death		4c. County of Death				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If	Under 24 Hrs.	8. Date of Birth		9. Birthp	place (State or Foreign		
	Director		220–66–4966	Hours Min.	(Month, Day, 02-20-19		Mary	yland		
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				1	0d. Inside City Limits		
	Maryl -f sho	ţo	MD Wicomico Salisbury					1 Yes 2 No		
	or 28a	Directo	10e. Street and Number 351 Deers Head Hospital Rd 10f. Zip Code		10	g. Citizen of V	Vhat Cour	ntry?		
	238 c		Emerson Avenue 21801			US.	A			
	er de	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispa If Yes, specify Cuban, M	anic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - Americ k, White,	etc.		
36	irs aft	by F	1 Never Married 2 Married 1 □ Yes 2 No 3 □ Widowed 4 □ Divorced Year or Dates:	Specify:		Specify	Whi	ita		
Ö	itled within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show the than headical Examiner must be notified at		15. Decedent's Education 16a. Decedent's Usual Occupation			6b. Kind of Bu				
213	ithin 7	Completed	(Specify only highest grade completed) (Give kind of work done durit life. DO NOT use retired)	ing most of work	ing					
2	led w lygier her th	S	12 none Secretary	N 84-46-4- 81	e (First, Middle, M	own Of				
anc	m = 0 5	Be				aloen Sumam	Θ)			
2	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene 1 show is marked other than "natural", or items 23a or 28a-1 show is marked other than "natural", or items 23a or 28a-1 show aumatic event. The Madical Examinational Learning at	မ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and	Eva Lea Number or Run		City or Town,	State, Zip	Code)		
S	alth ar		Jerry Bozman/Brother 31870 Wildwood							
more, Maryland 21215-0036	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic a <u>once.</u>		20a. Method of Disposition 20b. Place of Disposition (Name of cemelary, crematory or other place)		Date 2	Oc. Location -	City or To	own, State		
Ĕ	Pages ment of ant: If it ury or o		'4 □Donation 5 □Other (Specify) St. Peters U.M. Cen	m. 03/0	03/2006_0	riole,	Mar	yland		
Balti	ermit. Depart Inport Iny inj	1	21 Signature of Funeral Service Licensee 22. Name and Address of Hinman Funer		2					
	dD = e d	-	23. Part 1. Enter the the se, or complications hat caused the death. Do not enter the mode of dying, s				e, MI	218 <u>53</u> Approximate		
		1	shock, or heart failure. List only one cause on each line.		or respiratory arre	51,		Interval Between Onset and Death		
	Physician /Medical	16	mmediate Cause (Final disease or condition resulting in death) As ination Pneumonia Due to or as a consequence of):				-	Days		
84	Examiner		Amoric Enceuhalopat	hy				Years		
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	/						
	and -trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				1			
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit		Sub-to (of as a consequence of).				9			
687	ificate g phys	edicai	d							
ŏ	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy			23d. Dat	e of delive	ery		
O. B	e deat he att	sicia	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)			Moi	nth	Day Year		
<u>Р</u>	res that the de signed by the a be detached f	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	in Part I	23a Did tah	acco use cont	ribute to ti	ne cause of death?		
Records,	signe d be d	d by	Gastropophagen Reflux Dijeare	HI F 61().	1 □ Ye	\$/		pably 4 Unknown		
COL	w require been sig should b	lete			24a. Was ar	24b V	Vere auto	psy findings available		
Re	The law cate has page 2:	Completed			autopsy perfort	r Heyel?	rior to co leath?	impletion of cause of		
Vital		a)	25. Was case referred to medical 26	6. Place of Deat	1 Yes 2 h (Check only one		□Yes	2)S No		
	d is	To B		Nursing Ho	ome 5 Reside	nce 6 Oth	er (Specif	y)		
Division of	Attending Physician: r death. ector: After this certifice by the funeral director.	ion:	27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?		28d. Describe ho	w injury occurr	ed			
Sic	I or Attendi after death Director: A in by the fi	icat	3 Suicide 6 Could not be 290 Bloom of fairner. At home form street forting	s 2 No	28f. Location (Str	eet and Numb	er or Rurs	Al Route Number		
<u>≥</u>	after after Dire	Certification:	4 Homicide determined determined building, etc. (Specify)		City or Town		07 07 7 1072	in riodio rvanibor,		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral		29a. Certifier 10 Certifying Physicien: To the best of my knowledge, death occurred at the lime,	date and place,	and due to the ca	use(s) and ma	nner as s	tated.		
	the Holin 24 the Fu	edical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinione) and manner stated.					* '		
	To To	Σ	29b. Signature and title of certifier 29c. License no		29	d. Date signed				
,			Ceepon In Staff physician Doob	3368		2/20	3/20	06		
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DONG HYUN UEE M.D. 351 Deers Head Road, So	alishmy	140 2120	}				
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature		430					
	Registr	ar	MAR 0 6 2006 Steen de Coule							

			Ple	ease Type or Pr				. Ensure A Health and I	-		gible.	
			1 - For State Registrar	State of N	narytaric		rtificate of			Reg. No.	I CI C	00207
	Physici /Medio		Decedent's Name (First, Mic Pamela Pri	ce Burke					2. Date of De Month Feb.	24, 2	Year 2006	9:00p M
	Examir Funeral Director	er	5. Social Security Number 215-52-2468	Hospice H		st birthday Yrs.	L		n	Aı		cundel place (State or Foreign ntry) MD
	faryland f ehow	or	Usual Residence of Decedent 10a. State 10b. Cour MD Anne	e Arundel	10c. City,	, Town or L	ocation Pasade	ena				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	3a or 28a-	Funeral Director	10e. Street and Number 1484 West Cl	1 1			10f. Zip Code	21122		10g. Citizen	of What Cou	•
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 ie marked other then "natural", or Iteme 23e or 28e-f ehow ethy Injury or other traumatic event, I're Modical Examinar must be notified at once.	þ	11. Marital Status 1 Never Married 2 M 3 X Widowed 4 Divorce	If Yes, Give	s? ZiNo	5. 13.	Was Decedent of If Yes, specify Cul	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or N o Rican, etc.)		Race - Ameri Black, White, ecify:	
21215-0036	vithin 72 ho ne. hen "natur Msd fall	Completed			or 5+)	(Give	DO NOT use retire	during most of wor		Balti		dustry Iighlands School
Maryland 2	uld be filed w dental Hygie rked other t tlc event, th	To Be Co	17. Father's Name (First, Midd Palmer Danie			Teac	ier/keaur	18. Mother's Nan		e, Maiden Sur		SCHOOL
, Mary	and 2 shorestiff and N 27 le ma		19a. Informant's Name/Relation Zach Burke/So					f Drive,			wn, State, Zij 21122	
Baltimore,	Pages 1 ment of He ant: If Iten ury or oth		20a. Method of Disposition 1 ★Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other	on 3 □Removal from State (Specify)	te cei	elanc	osition (Name of ematory or other pla Memoria	l Pk.	. 28, 2006	Balt:	on - City or T	MD
Balt	permit. Depart Import eny Inj		21. Signature of Funeral Servi	ce Licenson		j	Rame and Add Barranco 495 Gov.	& Sons, Fritchie H	A. Sev Wy, Sev	verna P verna P	ark Fu ark, M	neral Home D 21146
e e e	Physician /Medical Examiner	16	23a. Par1. Enter the disease, shock, or heart failure. Limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a	as a consequence as a consequence	ൃഹാ ence of):	nter the mode of dy	ing, such as cardiac		arrest,		Approximate Interval Between
68760,	certificate be executed nding physician and use as the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1 c	as a conseque							
P.O. Box 6	death certif e attending id for use a	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 ☐ Fetal of at time of dea	death 3	□Ectopic pregnan □ Other (specify)	су		23d	Date of deliv	ery Day Year
	law requires that the as been signed by th 2 should be detache	ρχ	Part II. Other significant cond	litions contributing to death	but not resul	Iting in the	underlying cause g	iven in Part I.		tobacco use		the cause of death?
Vital Records,	: The law re cate has be page 2 sho	Completed								s an 2 opsy formed? 2/XINo	4b. Were auto prior to co death? 1 \sum Yes	opsy findings available ompletion of cause of
Division of Vita	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification: To Be	E LI Addident	Hospital: 1 Inpa	njury Day Year)	ER/Outpatie 28b. Time Injury	of 28c. Inju	ury at ork? □Yes 2 □ No	lome 5 Res	ndence 6	curred	who ship fell
Dİ	spital or Attendours after deatl	I Certifi	4 Homicide dete	ermined 289. Place of building,	etc."(Specify))	treet, factory, office		City or To	own, State)		al Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier 1 Certifier (Check only 2 Medicone) 29b. Signature and title of certifier (Check only 2 Medicone)	lying Physician: To the becal Examiner: On the basis and manner	of examinati	ion and/or i	nvestigation, in my	opinion, death occu	irred at the time	, date and pla	gned (Month,	o the cause(s)
	F 3 F 3		30. Name and address of person	3000	Goden (Mem	23a) (Type	Print)	1315	7	Feb.	nay o	27,2006
	Sta Regist		3 Date filed (Month, Day, Ye	The second secon	krar's Signati	ure	And .	··) 6-/ T	1 0 0/ 3	11/1/4	. 4	1
							A STATE OF THE PARTY OF THE PAR					1

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY 28 Year Day **Physician** 3.00 PM Robert Baker /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL GOOD SAMARITAN BALTIMORE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 08/04/1936 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) West Virginia **Funeral** 1**X** M 2□ F 69 **Director** 232-58-5320 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. and if item 27 is marked other than "natural", or Items 23a or 28a-1 show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Completed by Funeral Director 1X Yes 2 No WV Marion Ida May 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 227 Pine Street 26576 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steelworker L.T.V. Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ola Brock 2 Frances Baker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert W. Baker 290 Triple H Lane Lincolnton, NC 28092 importent: If item 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Omega Crematory 03/08/2006 Morgantown, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL INFARCTION Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medicai use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by RENAL FAILURE 1 Yes 2 No 3 Probably 4 Wunknown DIABETES MELLITUS 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2 1 No 1 Yes 1 TYAS Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred s after dea. of Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funerel D 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b, Signature and title of confier 29c. License number RESOCO tebruary 28,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raven Blud Baltimore, MD21239 NICOLAI MEJEVOI, 5601 Loch 31. Date filed (Month, Day, Year) 32 Registrar's Signature Registrar MAR 0 2 2006

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene State Registrar Amended item #2 per dr/wichd Gertificate of Death 3-14-2006/diles No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 02/26/2006 3. Time of Death Physician Month BRUCE 0950 M CLARK BAUER Scotember /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Peninsula WICOMICO Legional medical 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) Sex 1XM 2□F **Funeral** Days Months Hours Director 181-28-6662 Yrs. 69 14, AUGUST 1936 PENNSYLVANIA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County and Manial Hygiene. Is marked other then "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner count for notified at 10d. Inside City Limits 1 ☐ Yes 2 No DELAWARE SUSSEX SELBYVILLE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9B BAYVIEW EAST 19975 death USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours efter 1 XYes 2 No If Yes, Give Year or Dates: 1954-57 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No WHITE Specify: Specify: Ď 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) VETERANS ADMIN. CIVIL ENGINEER 4 permit Pages 1 and 2 should be file.
Deperment of Heelin and Manfal Hygi Important: If Itan 27 ie marked eny injury or other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HAROLD BAUER **EVELYN** 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9B BAYVIEW EAST, SELBYVILLE, DELAWARE 19975 BRENDA P. BAUER/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CREMATORY OF DELMARVA 3/4/06 DELMAR, DELAWARE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part. Enter the disease, or combilidations that caused the death, shock, or heart failure. List only one cause on each line. HASTINGS FUNERAL HOME, SELBYVILLE, DE. Approximate Interval Betwoods and De Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Examine ettending physicien and for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the e o 9 ☐ Unknown sete hes been signed page 2 should be det significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records. 3 Probably 4 ☑ Onknown 1 □ Yes 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate hes autopsy performe 2 No of Vital 1 Yes 2 No 1 🗌 Yes Be 25. Was case referred medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: 1 Unpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Yes 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Mann Jof Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred il or Attending Patter death.
I Director: After to in by the funera After 1 Division 1 Vatural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Mospital of within 24 hours eff.
To the Funaral Diff. 29a Certifier (Lifernitying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature 29c. License number 29d. Date signed (Month, Dav. Year) ed cause of death (Item 23a) (Type, Print) 60 KINEUSEC SALISBUR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

VET	н т. в	BUT	Ten#23a,27, penMe, g853, State of Mary 1- State Registrar 1. Decedent's Name (First, Middle, Last)		artmen rtificat			2. Date of D	Reg. No:	006	08211	
al of	Physic /Medi Exami	cal	KENNETH THOMAS BUTLER 4a. Facility Name (If not institution, give street and number) CIVISTA MEDICAL CENTER			Town, or LATA	Location o	Month MARCI	4c. C	Year 006 ounty of Death HARLES	1422 P ^M	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In 219-72-3923 1XIX 2 F 5	yrs. last birthday) Yrs.	If Under Months		If Under 2 Hours		lay, Year)	Cou	place (State or Foreign ntry)	
	the Marylan 28a-f ehow rotilled at	rector	10a. State 10b. County 10c MARYLAND CHARLES 10e. Street and Number	. City, Town or Lo		Code			10g Citize	n of What Cou	10d. Inside City Limits 1 ☐ Yes 2√√No	
0.36	permit. Pages 1 end 2 should be lided within 72 hours atter death with the Maryland Deperfunent of Heelth and Mental Hygiene. Important: If term 27 is marked other than "natural", or Itams 23a or 28a-f ehow minoriant: If term 27 is marked other than "natural", or Itams 23a or 28a-f ehow any injury or other traumatic event, the Mudical Exercities must be notified at once.	by Funeral Director	14630 SOUTH CUCKOLDS CRE 11. Marital Status XIXNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	in U.S. 13.		206 lent of His rfy Cubar		in? (Specify Yes or N Puerto Rican, etc.)	U 10- 14	. S . A . Race - Ameri Black, White,	can Indian,	
21215-0036	ed within 72 ho ygiene. ner than "natur it, the Medical I	Completed	15. Decedent's Education (Specify onfy highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us	k done di e retired)	uring most		N/		dustry	
Maryland	and Mental H and Mental H markad oth	To Be	17. Father's Name (First, Middle, Last) THOMAS BUTLER 19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address		ELI	's Name (First, Middle ZABETH C r or Rural Route Num	. EDE	LEN) Code)	
Baltimore, M	mr. rages 1 end 2 ertment of Heelth a ortant: If item 27 is injury or other tra			b. Place of Dispo cemetery, cref Y GHOST	sition (Nan matory or o	ne of ther place CEM)	Date 03-11-06	20c. Loca	tion - City or To	MD 21401 own, State	
P	hysician /Medical		23a. Part 1. Enter the disease, or complications that eaused the complex cause on each line. Immediate Cause (Final disease or condition resulting in death) The complex cause on each line. Intracranial condition resulting in death) Due to (or as a condition cause on each line)	death. Do not ent	RAYM LA P ter the mode	OND	FUNI	ERAL SER'	2064		Approximate Interval Between Onset and Death	
9700,	physicien and sthe burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a non death)									
T.O. 50X 0	ned by the attending pi detached for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of prediction in the past 12 months? 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pre Other (spe				230	d. Date of delive Month	ery Day Year	
oras, r	been signed bi	þ	Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying ca	iuse giver	n in Part I.		tobacco use		ne cause of death?	
tal neci		e Completed	25. Was case referred to medical				Oc. Plane		opsy ormed? 2 \(\subseteq No	24b. Were auto prior to co death? 1 XYes	psy findings available mpletion of cause of 2 No	
DIVISION OF VITAL RECORDS,	h. After this funeral di	Certification: To B	examiner? XXYes 2 No	2XXER/Outpatien 28b. Time of Injury		A Other Bc. Injury	4 □ Nur	sing Home 5 Res	idence 6		y)	
ביים	등등등		4 Homicide determined 256. Place of Injury - 4 building, etc. (Sp	ecify) knowledge, death	n occurred a	at the time	, date and	City or To	own, State)	nd mannet as si	il Route Number,	
To the chief	within 24 hours of To the Funaral I	Medical	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated. 29b. Signature and title of certifier	nination and/or in	vestigation,	in my opi	nion, death	n occurred at the time	, date and pl	d. Date signed (Month, Day, Year) MARCH 5, 2006		
	Sta	ite	30. Name and address of person who completed cause of death (ANA RUSIO, MD 31. Date filed (Month, Day, Year) 32, Registrar's Si	111 PI		REET	, BAI	TIMORE, MAI	RYLAND	21201		

ORIGINAL

Certificate of Death

4b. City, Town, or Location of Death

1. Decedent's Name (First, Middle, Last)

SHARFF

4a. Facility Name (If not institution, give street and number)

BREEDEN

CHRTIS

Physician

Examiner

/Medical

State of Maryland / Department of Health and Mental Hygiene

Reg. No.

2. Date of Death

3. Time of Death

3:20PM M

Day 2006 MARCH 7,

4c. County of Death

MONTGOMERY

Birthplace (State or Foreign Country)

VIRGINIA

10d. Inside City Limits

1 ☐ Yes 2√ 10g. Citizen of What Country?

U.S.A.

14. Race - American Indian, Black, White, etc.

Specify: WHITE 16b. Kind of Business/Industry

OWN SELF

18. Mother's Name (First, Middle, Maiden Sumame)

EPPERT

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

MD 20603

20c. Location - City or Town, State

3-13-06 | CHARLOTTESVILLE, VA

Approximate Interval Between Onset and Death

23d. Date of delivery Day

Year

1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 2⊠ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

MARCH 8, 2006

KSHAMA GARG, 1500 FOREST ROAD, SILVER SPRING, MARYLAND 20910 GLEN 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAR 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

i 0

			State of Maryland / Department of Health and 1- State Registrar Certificate of Death		2006	00013
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of Dea	teg. No. UU	3. Time of Death
	Physici		NANCY CROUCH CLARK	Month MARCH	12 2006 Year	2:40p M
	/Medic Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dec		4c. County of Dea	
	LAGIIII	ei	Chester River Hospital Center Chestertown		Kent	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hi	rs. 8. Date of Birth	9. Bir	thplace (State or Foreign
	Director		214-66-9894 1 M 2 F 61 Yrs. Months Days Hours Mi	sept I	7 1944 M	aryland
	p ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			
	anyla shov	-				10d. Inside City Limits 1
	28a-1	Director	MD Queen Anne's Crumpton 10e. Street and Number 10f. Zip Code		10 000	21
	with a or	ä	10e. Street and Number		10g. Citizen of What Co U.S.A.	ountry?
	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-1 show event, i're Medical Exemple must be notified at	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	(Specify Yes or No-		erican Indian
0	r Iter		1 Never Married 2 Married 1 Yes 2 12 No	erto Rican, etc.)	Black, Whit	e, etc.
ğ	rai', o	by	3 ☐ Widowed 4 ☑ Divorced It Ÿes, Give 1 ☐ Yes 2 ☒ No Specify:		Specify:	white
2 - -	72 hc	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of w	vorkina	16b. Kind of Business	/Industry
21	th	npie	Elementary/Secondary (0·12) College (1-4or 5+) life. DO NOT use retired)			
2	led w lygier har ti	00	2 Licensed Practical			Home
and	hair H	Be		lame (First, Middle,		
Maryland 21215-0036	ges 1 and 2 should be filed w t of Health and Mental Hygier If item 27 is marked othar th or other traumatic event, Its	은	Maurice Crouch, Sr. Katie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or I	Patrick		Zin Conto)
<u>≅</u>	d 2 s th an trau		Meredith Lefort (daughter) 29122 Tanager Way			
	Heal Heal tem		20a. Method of Disposition 20a. Method of Disposition 20b. Place of Disposition (Name of competery, crematory or other place)	-	MD • 2182 20c. Location - City or	
<u></u>	Pages nent of I int: if it		1 1 Donation 3 □ Removal from State (Specify) Chester Cemetery 3/1		Chesterto	
altimore,			21. Summer of Funeral Service the user			
ñ	permit. Departr imports any inj		Galena Funeral	Home of	Stephen	L. Schaech
			23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi	iac or respiratory arr	ena, MD.	Approximate
	Physician	8	shock, or heart failure. List only one cause on each line. Immediate Cayse (Final			Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a			
	Examiner		Sequentially list conditions b.			
7	ם ב	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	ecute and trans	Examiner	that initiated events c.			
3/60,	icate be executed physician and s the burial-transit		Due to (or as a consequence of):		1	
	physi the b	dicai	d			
X 6	death certificate e attending phys id for use as the	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d Date of dol	ivon
X Q Q	atter d for u	ciar	in the past 12 months?		23d. Date of del Month	Day Year
o.	the d by the	Jysi	1 ☐ Yes 2 12 No 9 ☐ Unknown 9 ☐ Unknown			
 J	law requires that the de as been signed by the a 2 should be detached f	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
2	w require been sig should b			1 10	es 2 No 3 Pr	obably 4 Unknown
ecords,	aw re	Completed		24a. Was a	in 24b. Were au	itopsy findings available
r	0 = 0	mo		autops perform	med? death? 2 No 1 ☐ Yes	atopsy findings available completion of cause of
Vital	ysician: The is certificate director, pag	BeC	25. Was case referred to medical axaminer?	eath (Check only on		
0 0	dii d	9	1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing	Home 5 ☐ Reside	ence 6 Other (Spe	cify)
Ē	ding Ph h. After th funeral	on:	27. Manner of Death 28a. Date of Injury 1 Phatural 5 Pending (Month, Day Year) 28b. Time of 28c. Injury at Injury Work?	28d. Describe ho	ow injury occurred	
200	teath death tor: / the f	cat	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be	001 1 11 10		
DIVISION	af or Attending F s after death. I Director: After i d in by the funera	ertification;	4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town	treet and Number or Ru n, State)	irai Houte Number,
_	Hospitat or 24 hours after Funeral Directly filled in	O	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plan	ce, and due to the co	ause(s) and manner as	stated
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	curred at the time, d	ate and place, and due	to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and the of certifier 29c. License number	2	9d. Date signed (Mont	h, Day, Year)
			I lennes 13 Melakoals Hoolo2423	•	03/14/	200G
	m		30. Name and/address of person who completed cause of death (Item 23a) (Type, Print)		1	
			Jennifer delaRosa, D.O. 6602 Church Hill R	d. Chest	tertown,	MD. 21620
	Sta		31. Date filed (Month, Day, Year) MAR 1 7 2006 32. Registrar's Signature			
	Registr	ar	MAR 1 7 2006 Blow & Spells			

Please T

ype or Print in Black Indelible Ink. Ensure A	II Copies Are Legible	
State of Maryland / Department of Health and M	Mental Hygiene 0 0 6	08214
Certificate of Death	Reg. No.	
	2. Date of Death Month Day Yea	3. Time of Death

Physici /Medic Examir

1 - State

Funeral Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Itam 27 is marked other then "natural", or Itams 23a or 28a-f show any Injury 92 other traumatic event, the Medical Examinat must be notified at once.

Baltimore, Maryland 21215-0036

Pnysician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funaral Director: After this certificate hes been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	- negistrar					timouto or	Douth		Heg. r	40.		
an	1. Decedent's Name HENRIET			итн сні	SHO	OLM		2. Date of D Month Februa		Day 27	Year 2006	3. Time of Death $10:05\text{A}^{\text{M}}$
er 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 1304 Mimosa Lane Silver Spring Montgomery												
	1304 Min	nosa Lane				Silver	Spring			Mont	gome	ry
	5. Social Security N			je (In yrs. last birth		If Under 1 Year Months Days			irth		9. Birth	oplace (State or Foreign
	578.48.29	04	□M 2 x F	98 Y	rs.		1.00.0	April				nsylvania
	Usual Residence of 10a. State	10b. County		10c. City, Town	or Lo	cation						10d. Inside City Limits
0	Maryland	Montgome	a r w			Spring						1⊈ Yes 2 No
rect	10e. Street and Num		ELY	DIIVE		10f. Zip Code			100.0	Citizen of	What Co	untry?
	1304 Mim	osa Lane				20904				. S . A .		
era	11. Marital Status	Du Dune	12. Was Decedent		13. \	Was Decedent of H	lispanic Origin? (S	Specify Yes or N		1		ncan Indian,
Ē	1 Never Marrie	ed 2 Married	Armed Forces?			f Yes, specify Cub		to Rican, etc.)			ck, White $y_{c} \cdot B1$	
d by	3 🖾 Widowed	4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🖾 No	Specify:			Specif	у: вт	ack
Completed by Funeral Director	(Speci	15. Decedent's Edity only highest gra		1	Give.	dent's Usual Occup	during most of wo	orking	16b.	Kind of B	usiness/l	ndustry
m id	Elementary/Secon	ndary (0-12)	College (1-4or	5+)		DO NOT use retire				7.1		
ပိ	4 Years Registered Nurse Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)											Services
Be c	The Francisco		mith				Marie			Cole	110)	
5	19a. Informant's Na			19b.	Mailin	ng Address (Street					State 7	in Code)
		ondon/Da		1		Mimosa L						
1	20a. Method of Disp	osition		20b. Place of I	Dispo	sition (Name of matory or other pla		Date	_			Town, State
	1 ☐ Burial 2 ☐ 4 ☐ Donation	☐Cremation 3 ☐ 5 ☑Other (Specifi	Removal from State /)Entombmen					14/2006	LIa.	ah i na	.t.o.n	D.C.
Н	21. Signature of Fur			,	22	Name and Addre	ss of Facility				LOII,	р.с.
	HINES-RINALDI FUNERAL HOME, INC. 11800 New Hampshire Ave, Silver Spring, MD 20904											
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line.											Approximate Interval Between
, 1	Immediate Cause (Final disease or condition a. Uterine Cancer											Onset and Death
	resulting in death)	-	a	a consequence of	f):							
Sequentially list conditions, Dementia Due to (or as a consequence of):												
Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Dive birth 2 Fetal death 3 Ectopic pregnancy												
каш	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):											
E			Ede to (or as	a consequence of).							
dic			. d									
₹ M	IF FEMALE: 23b. Was decedent	orognani	23c. If yes, outcome							23d Da	te of deliv	(en)
	in the past 12 i	months?	1□Live birth 4□Pregnant at	2 Fetal death time of death		Ectopic pregnancy Other (specify)	1				onth	Day Year
Completed by Physic	9 Unknown	1140	9□ Unknown									
y P	Part II. Other signifi	cant conditions c	ontributing to death b	ut not resulting in t	the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco	use cont	nbute to	the cause of death?
edt	Hyperte	nsion						1 🗆	Yes	2 🔯 No	3 🗆 Pro	bably 4 Unknown
piet								24a. Wa		24b.	Were aut	opsy findings available
E O								per 1 Yes	opsy omed? 2)2 N	'	death?	ompletion of cause of 2 ☐ No
Bec	25. Was case referrence examiner?	ed to medical					26. Place of De	ath (Check only		10		
2	1 ☐ Yes 2 🔀 1	No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outp	atien	t 3□ DOA Oth	er: 4 🗆 Nursing I	dome 5₺ Res	idence	6 □Oth	er (Speci	ify)
on:	27. Manner of Death	5 Pending	28a. Date of Inju (Month, Da	ry 28b. Tir y Year) Inj	me of ury	28c. Injur Wor	y at k?	28d. Describe	how in	ury occur	red	
cati	2 Accident	investigation					Yes 2 □ No					
Ē	4 Homicide	determined	28e. Place of Inj building, et	ury · At home, farr c. <i>(Specify)</i>	ກ, stre	eet, factory, office		28f. Location City or To	(Street a	and Numb ite)	er or Rui	ral Route Number,
ပိ	29a. Certifier	1 V Cartifuina Dh	traicians To this beat	of market and a dear	No.				Nesitto CV		and the same	12000A
Medical Certification:	(Check only one)	2 Medical Exam	ysicien: To the best niner: On the basis of and manner sta	f examination and/	or inv	estigation, in my o	pinion, death occi	a, and due to the urred at the time	, date a	nd place,	and due	etated. to the cause(s)
29b. Signature and title of ceptifier 29c. License number 29d. 1								29d. D	ate signe	d (Month,	, Day, Year)	
	1/2	170	Ne, m T	1		D-22	8/10			ırch		
1	30. Name and add	ss of person who	mpleted cause of d	leath (Item 23a) (T	уре. 1		U-TU		1.15	-1 -11	1, 4	
			, 12201 P			,	ilver Sp	ring, M	ary1	and	2090	4
e	31. Date filed (Monti	h, Day, Year)	32. Pagistr	ar's Signature	1	e fi		Ų, 11.	. 7 -			
ar	N	IAR 03 2	2006	w D.	200	The state of the s						

Registrar

State

State of Maryland / Department of Health and Mental Hygiene [] [] [Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Feb 28 **Physician** Daniel Edwin Cameron 2006 11:20 A M /Medical 4a. Facility Name (If not institution, give street and number)
Charlotte Hall Veterans Home 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Mary's Charlotte Hall If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
July 8 1927 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 JM 2 □ F 577-34-1691 78 Alabama Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 ie marked other than "naturel; or itema 23a or 28a-f ehow ury or other traumatic event, the Michigal Examinar must be nutilised at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Maryland Funeral Director St. Mary's Charlotte Hall 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 29449 Charlotte Hall Road 20622 United States Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 SYes 2 No If Yes, Give Year or Dates46-49 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No white Specify: Completed by 3 ➡Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) post Office US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Owen Keesee Cameron Edna Florence Rote 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11726 Hilltop Road Lusby, MD 20657 Grace Korn- stepdaughter 20b. Place of Disposition (Name of cemetery, crematory or other place). 2 2006 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: if eny Injury or once. Alexandria Virginia 4 □ Donation 5 □ Other (Specify) Metropolitan Funeral Service 22. Name and Address of Facility Rausch Funeral Hore 21. Signature of Funeral Service Licensee 4405 Broomes Is. rd. Port Republic MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ORONAR disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physicien and s tha burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical as attending | for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the s should be detached 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗆 Yes Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No certificate 1 Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient ٢ 3□ DOA this After thi funeral of 27. Manner of Death

Natural

Control

Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation er death. Irector: A' in by the fr 1 ☐ Yes 2 ☐ No М 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t within 24 hours efter of To the Funeral Direct completely filled in by 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29b. Signature and title of certifier o completed cause Teath (Item 23a) (Type, Print) 32. Registrans Signature 31. Date filed (Month, Day, Year) State 2006▶ Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month February 26, 2006 9:42 p M Carroll Lillian Genevieve /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12112 Palisades Drive Calvert Dunkirk If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 💢 F Director 85 Yrs 215-34-3171 1920 Maryland Usual Residence of Decedent the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or items 23s or 28s-f show other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 No Directo Dunkirk MD Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20754 12112 Palisades Drive death v by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or item any injury or other traumatic event, the Medical Examples 2002. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Norfolk Eddie Mary E. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12112 Palisades Drive, Dunkirk, MD Charles E. Carroll, son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) So. Memorial Gardens 03-03-2006 Dunkirk, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Por Rausch Funeral Home, P.A., Owings, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DEMENTIA disease or condition resulting in death) 1EARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physician and I for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) Records, P.O. 1 ☐ Yes 2 No deteched the 9 Unknown 9 Unknown cate has been signed by page 2 should be detech Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy performed? 1 Yes 2 No Division of Vital the Hospital or Attending Physician: : After this certifical funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ₹ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending hours after death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funersi Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MI 040370 February 28, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20678 110 Hospital Rd., Suite 310, Prince Frederick, MD Peter L. Wisniewski, M.D., 31. Date filed (Month, Day, Year) 32. Registra s Signature State 2006 Corner Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav CATLIN Month Year 07.03 **Physician** 28 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner university of Mondand Medical Center Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 07-07-1938 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5 Social Security Number **Funeral** MM 20F Maryland 215-38-1398 67 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County Itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director Princess Anne MD Somerset 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21853 USA 11930 Sherree Lane permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural; or itame 23a any injury or other traumatic event, Ita Medical Examination once. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Catlin's Paving Owner/Operator 12 none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Keturah Catlin Elmer F. Catlin 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11930 Sherree Lane, Princess Anne, MD 21853 Joyce Catlin/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 03/04/2006 Princess Anne, MD Beechwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Eacility
Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, MD 21853 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebral Marct Physician day(disease or condition resulting in death) /Medical Sibarachnoid hemovrhage Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit nev Celebral Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) sate has been signed by the a page 2 should be detached? 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy this certificate 2. No 1 Yes Hospital or Attending Physician: : After this certification funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1x Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending death. 2 No investigation Director: / 2 Accident 6 Could not be determined 3 T Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Direct 4 - Homicide 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examine. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) . 1 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number # 15818 28, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.O. 22 South Greene St, Mark Guchi, Baltimore

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month,

32. Regigiar's Signature

affice

2006

			For State Registrar	State of Man	yland / Depa		Health and N	Mental Hygi	ene	00010
			Registrar 1. Decedent's Name (First, Middle, La.	oel .	Cer	lilicale of	Dealii	Re-	g. No.	3. Time of Death
.30	Physici	an		,				Month	Dav Year	
6	/Medic	al	Edith Elizab			1) O' T-			4, 2006 4c. County of Death	9:28 p ^M
	Examin	er	4a. Facility Name (If not institution, giv	e street and number)			or Location of Death			
			Anne Arundel N 5. Social Security Number 6. S	Medical Ce	nter In yrs. iast birthday)	If Under 1 Year	Annapoli If Under 24 Hrs.	8. Date of Birth		Arundel
	Funeral Director			DM 257E	87 Yrs.	Months Days		(Month, Day, Dec. 18,	Year) Co.	place (State or Foreign intry) MD
			Usual Residence of Decedent					10,	15101	1.112
	nylan thow		10a. State 10b. County	curry	0c. City, Town or Lo				1	10d. Inside City Limits
	Ba-f	cto	MD Prince	George's		Solomor	ns 			1 ☐ Yes 2 🔀 No
	be filed within 72 hours after death with the Maryland tial Hygiene. do other than *natural', or Itams 23a or 28a-f show event, it a Medical Esa ninar must be notified at	Funeral Director	11750 Asbury Ci	rcle, #1413		10f. Zip Code 20	0688	10	g. Citizen of What Cou USA	intry?
	dea	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13. \	Was Decedent of I	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No-	14. Race - Amer Black, White	
9	or It	F	1 Never Married 2 Married	1 ☐ Yes 2 No	j	1 ☐ Yes 2X No		, , ,	Specify:	White
8	72 hours after natural', or Ita	d by	3 Widowed 4 Divorced	Year or Dates:						
5	nat alle	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of work	king 1	6b. Kind of Business/I	ndustry
12	e filed within al Hygiene. lother than "	m d	Elementary/Secondary (0-12)	College (1-4or 5+)		nmercial			Lockheed M	artin
9	filed Hygid Other ent,		17. Father's Name (First, Middle, Last))				ne (First, Middle, M		
a	id be ental ked o	o Be	Max Rohn				Ada Arno	old		
Maryland 21215-0036	should be nd Menta marked umatic ev	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street			City or Town, State, Z	p Code)
Ž	and 2 sealth ar m 27 is		. Quentin Curr	v/Husband					lomons, MD	
ē,	ges 1 and 2 should it of Health and Mer if Item 27 is marke or other traumatic		20a. Method of Disposition		20b. Place of Dispo cemetery, crem	sition (Name of		Date 2	Oc. Location - City or T	
9	Page ent o nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Juanio Aat noin State		: Cemete:	I PROLE	. 1, 006	Davidsonvi	lle, MD
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Licer	1500	22 I	Name and Address Barranco 195 Gov.			rna Park F	uneral Home MD 21146
775	Ash		23a. Part1. Enter the disease, or com	plications that caused th					1	Approximate
	Physician	8	shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	SEP	516				Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	aDue to (or as a c	consequence of):					
	Examiner			akk	consequence of):	GATW.	E UTI	′		
	* * *	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c						
	cuted id ransit	Examiner	fl any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C.						
o Î	be executed Ician and burial-transit		resulting in death) Last	Due to (or as a c	consequence of):					
3760,	5 × 6	Ical		d						
99	5 4 %	Physician/Medi	IF FEMALE:							
Вох	eath certif attending for use a	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2 [Ectopic pregnanc	ey .		23d. Date of deliv	very Day Year
Ö.	e dea the at	sici	1 □ Yes 25 ☑ No	4☐Pregnant at tim 9☐ Unknown	ne of death 5	Other (specify)			MOHIII	Day rear
P.O.	that the de led by the a detached f	Phy	9 Unknown	and the stine to death but a	ant annulsing in the	-4	in Dani I	22a Did taba	ann una anatributa ta	the source of death?
	ires tha signed d be det	by	Part II. Other significant conditions of the Part II.			nderlying cause gi	ven in Pan I.		accouse contribute to 2 □ No 3 □ Pro	
Records,	v requir	Completed	11/2011	i blood	40.			1 10		
ec	has b	nple	Amax	gestera	Voen			24a. Was an autopsy	DUOL to C	opsy findings available omptetion of cause of
=		Ö	C					perform 1 ☐ Yes 2	ed? death? No 1 ☐ Yes	2 🗆 No
Ž.	Attending Physician: The r death. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital: ~		100		th Check only one)	
ot	hys this	- To	1 Yes 27	Inpatient	2 ER/Outpatien	IL SLI DOA			nce 6 Other (Spec	ify)
E	Jing After funer	- Lo	Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	(ear) Zab. Time of Injury	Wo	ork? Yes 2 No	28d. Describe how	v injury occurred	
<u>S</u>	death death ctor;	cai	2 Accident investigation 3 Suicide 6 Could not b	e One Diese of leives	- At home, farm, str			28f Location (Stre	eet and Number or Ru	ral Route Number
Division of Vital	P Sign	Certification:	4 Homicide determined	building, etc. (Specify)	eer, ractory, onice		City or Town,		as ricole rember,
_	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.		29a. Certifier Certifying Pt (Check only 2 Medical Example)	nysician: To the best of o	ny knowledge, death (amination and/or inv	ruccurred at the to vestigation, in my	ime, date and place, opinion, death occur	and due to the cat red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Medical	29b. Signature and title of certifier	and manner states	u.					
	Too	-	Ma dia	M(Lang	1 000	7	0 4 -> 7 =	29	2 /200/	7.
		1	1/0.01/1	1 July 1	+	r of c	J433	/	a soft	0
			30. Name and address of pers who	completed cluse of deal	tn (nem-cla) (Type,	Print)	Rev & M	1)1)20071	5 mb 7	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature		11 17	,.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	() ()	-
	Registr			2006	W M	hanks.			d. Date signed (Month) 2 (24 (5)	

Amend # 8 per Phy. 3-2-06 A.A. Co.Health Dept.PM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Year Physician Ellen Maru orwel 26 2:00 P. February ,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Glen Burnie If Under 1 Year If Under 24 Hrs. Baltimore U Jashington Med Ctr. 8. bale 2 9 irth 1914 (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Days 21282676 2 Yrs. MD Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Iteme 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Anne Arundel Funeral Director MD Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 164 Old Annapolis Road 21146 USA filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2X No ģ 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Corwell's Food Elementary/Secondary (0-12) College (1-4or 5+) General Store Owner Market 12 s 1 end 2 should be filed v f Health and Mental Hygie item 27 is marked other t other traumatic event, ID other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Joseph Lannon Delia A. Garvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 s
Department of Health an
Important: If item 27 is
any injury or other trau Mary Patricia Woods/Daughter 268 Pertch Road, Severna Park, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Mar. 2, 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) New Cathedral Baltimore, MD 2006 21. Signature Funeral epvice Lices 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Hor 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death Failure Physician Heart LONGERBYL /Medical Due to (or as a consequence of): Examiner urosepsis Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. phys. the b ding pl IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a O 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? (es 20 No 2 No 1 Yes Yes Division of Vital director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ☑ No ↑ Inpatient 2 ER/Outpatient 3 DOA this After this funeral of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident investigation 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M-D 50055973 kerstehun FLECTUARY 26,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20904 Silver Spring suther land way Zeleke Desse 11500 31. Date filed (Month, Day, Year)

MAR 0 2 2006 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of M	laryland	•	artment tificate			and M		Reg. No.	06	08220
I	Physici	an	1. Decedent's Name (First, Middle								2. Date of Dea	Day	Year	3. Time of Death
	/Medic			ood Caulf			45 City 3	Tau-	Location of	(Death	March 1		ounty of Death	3:10 p м
	Examin	er	4a. Facility Name (If not institution 949 Leisters Ch	•	7				inste			40.00	Carro	
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. la:	st birthday)	If Under		If Under		8. Date of Birt	th Voas	9. Birth	nplace (State or Foreign untry)
	Director		219-12-1024	1⊠M 2□F	81	Yrs.	Months	Days	Hours	Min.	May 5,	1924		nsylvania
	Du ≱		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	cation							10d. Inside City Limits
	Maryla f sho	٥	Maryland Carr	roll				W€	estmi	nste	r			1 ☐ Yes 2€ No
	7.28a	rect	10e. Street and Number				10f. Zip	Code				10g. Citize	n of What Co	untry?
	th with	Funeral Director	949 Leisters	Church Road					211	157			USA	
	r dear	ner	11. Marital Status	12. Was Deceden Armed Forces	?	. 13. \	Was Deced f Yes, spec	ent of Hi	spanic Ori n, Mexican	gin? (Sp 1, Puerto	ecify Yes or No Rican, etc.)	- 14.	Race - Amer Black, White	
9	s afte	by Fi	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	ed 1 Yes 2 If Yes, Give Year or Dates:	TATE T		1 ☐ Yes 2	⊋ <mark>∏</mark> No	Specify:			S	pecify: W	hite
215-0036	within 72 hours after death with the Maryland piece. Then "natural" or Items 23e or 28e-f show the Madical Evands are mast be multified at	ted t	15. Decedent	's Education		16a. Deced	ient's Usua	Occupa	ation			16b. Kind	of Business/I	ndustry
215	thin 7.	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	kind of wor DO NOT us	e retired,)	t or work	ing	ТеТ	enhone	Company
N	i filed with I Hygiene other the rent, the	Con	11			S	Superv	71SO1						Company
Maryland	್ತ್ ಶ ಕ	Be	17. Father's Name (First, Middle, Elwood Raymo		1						e (First, Middle, May Cun			
Ž	is 1 and 2 should be of Health and Menta item 27 is marked other traumatic events.	၉	19a. Informant's Name/Relationsl			19b. Mailir	ng Address	(Street a			al Route Numbe			ip Code)
	and 2 sho Balth and n 27 is m		Rebecca A. Hai		er						estmins			157
altımore,	ss 1 and 3 of Health item 27 r other tr		20a. Method of Disposition	o CIR Chan		ice of Dispo	sition (Nam	e of ther place	9)		Date	20c. Loca	tion - City or 1	Town, State
Ĕ	Page ment c ant: If		1 ☑ Burial 2 ☐ Cremation 1 ☑ Donation 5 ☐ Other (Si		Lei	sters	Churc	ch C	em.	03/0	6/2006	Wes	tminst	er, MD
Balt	permit. Pages Department of H Important: If ite any injury or of once.		21. Signature of Funeral Service	icensee MC	1191	> 22	. Name and 91 Wil	d Addres Llis	s of Facilit Stre	y My eet,	ers-Dur Westmin	boraw ster,	Funer MD 21	al Home 157
			23a. Part1. Enter the disease, or sbock, or heart failure. List	complications that cause only one cause on each	line.									Approximate Interval Between Onset and Death
d	Pnysician		Immediate Cause (Final disease or condition	- Acute	- Mye	clode	10060	نه دخد	MI	reic	genous	Lev	Hemia	Sweek
	/Medical Examiner		resulting in death)	Due to (or a	s a conseque									
		e	Sequentially list conditions, if any, leading to introduce	b. Due to (or a	s a conseque	anea of):				_			- 1	
	d d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	с.										
Ď,	ate be executed hysician and the burial-transit	Exa	resulting in death) Last		s a conseque	ence of):								
	ate be	licai		d						-				
ý X	death certifica e attending ph id for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcom	e of pregnan	cv						220	i. Date of deli	ven.
Rox	atten atten	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal o	death 3□	Ectopic pre Other (spe					230	Month	Day Year
Ö		hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown										
č.	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant condition	ns contributing to death	but not result	ting in the u	nderlying ca	ause give	n in Part I		23e. Did to	1		the cause of death?
ğ	v require been sig										101	res 201	No 3□Pro	bbably 4 □Unknown
Records,	e lawr has be je 2 sh	Completed	<u> </u>								24a. Was autop	osy	prior to c	opsy findings available ompletion of cause of
_	The age	Con									1 Yes	rmed? 2 No	death?	2□ No
Vital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			h (Check only o		70	
ō	og Phys ter this neral dir	2	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of In	jury 2	R/Outpatier 28b. Time of		Bc. Injury Work	4 🗆 140		me By Resid			ity)
0	.5 . 5 . 5	ation	1 Natural 5 ☐ Pendin 2 ☐ Accident investig		ay Year)	Injury	м		<br Yes 2. □	No				
Division	al or Attendi after death. I Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 200. Place of I	njury - At hometc. (Specify)	ne, farm, str	eet, factory	, office			28f. Location (S City or Tox	Street and N vn, State)	lumber or Ru	ral Route Number,
ā	ital or rs afte ral Dir led in	Cer								Į				
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical		g Physician: To the bes Examiner: On the basis and manners	of examination									
	o the ithin i	Mec	29b. Signature and title of certifier				29c	. License	number			29d. Date s	igned (Month	, Day, Year)
)	1017		1 Gran	or Galia	TH		~	150	660			031	05/3	-006
	TIVA		30. Name and address of person		death (Item 2	23a) (Type,							1	
10	7 '		THOMAS GAI		Dall	STONE	IL A	ve_	MG	STW	un ste	L, MA	key listed	2115)
70	Sta Registr		31. Date filed (Month, Day, Year)	3 2006 32. Regis	rar's Signatu	ле Ж	board	<i>y</i> .						
100	9.0			- 2000		10		6						

		,	For State Registrar	State of Ma	aryland		artment <i>tificate</i>			and Me		jiene	006		082	21
	Æ		Decedent's Name (First, Middle, L.	.ast)							. Date of Dea	th			3. Time o	f Death
	Physici /Medic	an	Carroll, Joh	in Conw	av					/	March	Day			9:10	PM
	Examin	er	4a. Facility Name (If not institution, g	ive street and number)					Location o				County of D			
			Bultimore VA 1	redical C	ente				More	-	<i>y</i>		ltimo	re	City	
	uneral		5. Social Security Number 6.	Sex 7. Age	e (In yrs. las	t birthday) Yrs.	If Under '	1 Year Days	If Under 2 Hours	Min.	. Date of Birth (Month, Day	, Year)		Counti		or Foreign
	Director		217-38-5767 Usual Residence of Decedent		65	113.				0	8/21/1	940	M	ary.	land	
yland	Mon		10a. State 10b. County		10c. City, 7	fown or Lo	cation							10	d. Inside C	ity Limits
Man	fall and	ţō	MD Carol	ine	Gre	ensbo	ro								1 Yes	2 🗌 No
th the	or 28	Director	10e. Street and Number				10f. Zip	Code			1	l0g. Citiz	zen of What	Count	ry?	
ith wi	23a mat b		202 S. Main Stre	eet			2	1639)				USA			
or dea	tems Br.m	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. V	Vas Decede Yes, speci	ent of His fy Cubar	spanic Orig	gin? (Specif	fy Yes or No- can, etc.)	1	4. Race - A Black, W			
1215-0036 within 72 hours after death with the Maryland	o d	by Fi	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		, 1	□Yes 2	No	Specify:				Specify:			
5-0036 72 hours af	itural E		15. Decedent's	Year or Dates:]			lent's Usual	Occupa	tion			16h Kir	nd of Busine	whi		
15 in 72	Awalls	Completed	(Specify only highest g	rade completed)		(Give	kind of worl	k done di	urina most	t of working		IOU. KII	id of busine	SS/INUL	изиу	
Z With	the state	mo	Elementary/Secondary (0-12)	College (1-4or 5	+)	stee1	work	ter				st	eel i	ndu	stry	
2 DC	other vent, I	Be C	17. Father's Name (First, Middle, Las	st)	,				18. Mothe	er's Name (F	First, Middle,	Maiden .	Sumame)			
aryland	to wenter rygener in matural, or flems 23a or 28e-f show marked other than "natural", or flems 23a or 28e-f show matic event, the Modical Exercinar must be notified at	ToE	Carroll John Cor	way, Sr.					E11e	n Osw	inkle					
	0 00 Z		19a. Informant's Name/Relationship		1						Route Number				Code)	
	m 27		Carole Linton Cor	way / spous		and the second second			reet		ensbor	o, M	D 216	39		
altimore,	or of the		20a. Method of Disposition 1 Burial 2 Cremation 3	☐Removal from State	20b. Plac	e of Dispo: etery, cren	sition (Nami natory or oth	e of her place)	Date	θ	20c. Lo	cation - City	or Tow	vn, State	
tim Pa	tant:		4 □ Donation 5 □ Other (Spec		Easte					3/13/			lock,			
Balt Permit.	Important: If its any injury or o		21. Signature of Funeral Service Lice	ensee		F.J	Name and	Address	of Facility	fenbe	in Fun	eral	Home	, P.	A	
		-	23a. Part1. Enter the disease, or co	malications that caused	the death								9		Approximat	
			shock, or heart failure. List onl	y one cause on each in	10.							0 51,			Interval Bet Onset and	ween
/-	/sician ledical		disease or condition resulting in death)	Due to (or as a	obstr	veti	ve po	VIMO	nary	dis	ease			2	20 ye	ars
	aminer		1	Due to (or as a	a consequen	ice or):	•		/						,	
		Je.	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents	Due to (or as a	a consequen	ice of):										
cuted	ransit	Examiner	triat mitiated events	c.												
O S	ien al urial-t	Ë	resulting in death) Last	Due to (or as a	a consequen	ice of):										
HECORDS, P.O. BOX 68/60, The law requires that the death certificate be executed	physicien and	dical	•	d.											-	
er iji	attending p for use as	Med	IF FEMALE:	-								- 1		1		
BOX	for us	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth	2 ☐ Fetal de	ath 3	Ectopic pre					2	3d. Date of Month		•	Year
چ و	ched	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of deati	n 5∟	Other (spe	crfy)							,	
# that	ed by the a	면	Part II. Other significant conditions	contributing to death bu	ıt not resultir	ng in the un	iderlying car	use giver	n in Part I.		23e. Did tol	pacco us	se contribute	to the	cause of c	leath?
Hecords, he law requires t	ည်းရှိ	d by						-			1 🗆 Ye	∍s 2 []No 3 €	Probal	bly 4 □l	Jnknown
CO W	shou	Completed									24a. Was a	n	24h Wara	autono	eu findinge	avadable
E &		m C									autops perforr	ned?	24b. Were prior death	?		ause of
	certificate ha	0	25. Was case referred to medical						26 Place	of Dooth #	1 ☐ Yes :		1 🗆 Y	es 2	. No	
ysici	direc	0 0	examiner? 1 ☐ Yes 2 ※ No	Hospital:	nt 2□ER	/Outpatient	3□ DOA	Othor			5 ☐ Reside		□Other (S	necify)		
Phy Phy	After thi	ı.	27. Manner of Death	28a. Date of Injur (Month, Day	y 28	b. Time of	28	c. Injury Work			d. Describe ho			,,,,		
or ign	or: Af	atte	1 Natural 5 Pending 2 Accident investigate	on		,,	М		es 2□N	No						
DIVISION I or Attending	Direct in by t	Certification:	3 Suicide 6 Could not 4 Homicide determine		ry - At home . (Specify)	, farm, stre	et, factory,	office		28f	Location (SI City or Town		Number or	Rural I	Route Num	rber,
DIVISION OF VITA To the Hospitel or Attending Physician:	To the Funeral Director:		29a. Certifier 1 X Certifying P	hysician: To the best of	of my knowle	dge death	occurred a	t the time	date and	d place, and	due to the c	ause(s):	and manner	ac etal	led	
he Ho	he Fui pletely	edical	(Check only 2 Medical Exa	aminer: On the basis of and manner sta	examination	and/or inv	estigation, i	in my opi	nion, deat	th occurred	at the time, d	ate and	place, and o	lue to t	he cause(s	;)
Tot	Tot	Σ	29b. Signature and title of certifier	1			29c.	License			2		signed (Mo			
,			Bruh	MI	,			PI	828	81		Mo	arch,	6,	200	6
			30. Name and address of person who	completed cause of de	eath (Item 23	Ba) (Type, F	Print)	- 1	0	11".	re i	MIN				
		- 1	/) in the Kalant				202	7 T					/ / /	7 /	/	
200	Sta	te.	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	Gres	ene :) T.	Dal	Itimo.	re i	/ (1)	21	20	1	

			For Stata Ragistrar	State of Marylan		artment of H			ene	00000
et.	Physici	an	Decedent's Name (First, Middle, Last)	CECTI				2. Date of Death Month	Day Year	3. Time of Death
l à	/Medi Examir		FAYE ALICE 4a. Facility Name (If not institution, give st Menorial He	spital		4b. City, Town, or	ton		4c. County of De	of
140	Funeral Director		5. Social Security Number 6. Sex 216-38-9732	7. Age (In yrs. 62		If Under 1 Year Months Days	If Under 24 H Hours Mi			rthplace (State or Foreign Country) ryland
	e Maryland a-f show	ctor	10a. State 10b. County MD Caroli		y, Town or Lo		alsbur	- g		10d. Inside City Limits 1 May Yes 2 No
	3a or 28	i Director	10e. Street and Number 203 Academy Ave	enue		10f. Zip Code	1632		Citizen of What Conited St	
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-1 show aumatic event, the Medical Exantinar must be notified at	by Funeral	· · · · · · · · · · · · · · · · · · ·	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	H		spanic Origin? n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh	erican Indian,
Maryland 21215-0036	d within 72 ho giene. er than "natur the Medical	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12) 1 2		(Give	ent's Usual Occupa kind of work done o OO NOT use retired, Home ma	furing most of w)	vorking 16	Own Ho	,
yland	ould be file Mental Hyg warked othe	To Be C	17. Father's Name (First, Middle, Last) David Mitchell				Lula	lame (First, Middle, Ma Messick	,	
	tra		Joy L. Murray/Da					Ave. Fed		Zip Code) 21632 urg. MD
Baltimore,	permit. Pages 1 ar Department of Hea Important: If Item: any Injury or other once.		20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □ Re: 4 □ Donation 5 □ Other (Specify)	moval from State	lace of Disposementers, crem	sition (Name of patory or other place est Cem	9)		c. Location - City o	r Town, State
Balt	permit. Departi		21. Signal fe Fineral Service Licensee	m. Coal		Name and Addres	s of Facility			alsburg,MD
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.	U wo	× .		ac or respiratory arrest	,	Approximate Interval Between Onset and Death Z day S
8/60,	cate be executed by sicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)	,					
O. Box 68	ath certific attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
ecords, P	w requires that the de been signed by the should be detached	þ	Part II. Dther significant conditions contr COPD	buting to death but not resu	ulting in the un	derlying cause give	n in Part I.	23e. Did tobac		o the cause of death?
r	sicien: The law re certificate has bee irector, page 2 sho	Completed	Coronary	artery d	icea	r-e		24a. Was an autopsy performe	d? prior to death?	
r vital	iding Physicien: th. After this certifica funeral director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 Mo	spital: 1 [Inpatient 2]	ER/Outpatient	3□ DOA Othe		eath <i>(Check only one)</i> Home 5 Residence	e 6 Other (Spe	ocify)
DIVISION OF	tending Plath. tor: After to		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 🗆 Y		28d. Describe how		
Š	To the Hospital or Attending within 24 hours after death. To the Funerel Dirsctor: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	') 			28f. Location (Stree City or Town, S	State)	
	he Hosp n 24 hou he Fune bletely fil	edical	29a. Certifier (Check only one) 1 Certifying Physic 2 Madical Examine	r: To the best of my known. To the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the time estigation, in my op	e, date and place inion, death occ	ce, and due to the caus curred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within to the complex c	Σ	29b. Signature and title of certifier	mo		29c. License	number		Date signed (Mon	
			30. Name and address of person who com DK. Peter L. Whitese				Eastin	, md. 216	01	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Redistrar's Signat	ure	barles				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

	,				State of	maryıar	•	artment d <i>tificate</i>		ealth and M Death	ientai Hy	gien Reg. N	and the same	,c=	10000
			1. Decedent's Name (First, Midd	dle, Last)							2. Date of De	eath	. U U i)(3. Time of Death
	Physiciar /Medica		Aloysia Duga	ın							Month March			Year 5	5:20 A.M.
	Examine		4a Facility Name (If not institution		reet end numi	per)			4	o. City, Town, or Lo	ocation of Deet	h 4	c. County of	of Death	
1			St.Vincent (Care	Center					Emmits				deri	
	Funeral		5. Social Security Number	6. Sex	7 M. 25∑F	. Age (In yrs.	last birthday)	If Under 1 \ Months D		If Under 24 Hrs. Hours Min.	(Month, Da			9. Birthp	place (State or Foreign ofry)
	Director	-	199-03-7903 Usuel Residence of Decedent				87 Yrs.				May 8	<u>, 19:</u>	18 1	Penn:	sylvania
	show		10a. State 10b. Count	у		10c. Ci	ty, Town or Lo	cation						1	0d. Inside City Limits
	r 28e-f sho	į	MD Fre	ederi	ck	E	mmitsbu	ıro							1 Tal Yes 2 □ No
	death with the Maryland ms 23a or 28e-f show frust be notified at	<u>e</u>	10e. Street end Number	JUCII	CK		IIIII L CODE	10f. Zip Co	ode			10g. C	itizen of W	het Cour	itry?
	th wil	<u> </u>	335 South Se	ton	Avenue			21	L727	7		Ţ	J.S.A.		
	r iteme 23a		11. Marital Status		2. Was Deced		I,S. 13. V	Vas Dacedeni Yes, specify	t of His	spanic Origin? (Sp., Mexican, Puerto	ecify Yes or No Rican, etc.))-	14. Race	- Americ	an Indian,
36	0 0	y y	1 ☑ Never Married 2 ☐ Ma		1 ☐ Yes 2 If Yes, Give			□Yes 2⊠					Specify:	,	
21215-0036	"naturel", or its colon Examina	2	3 ☐ Widowed 4 ☐ Divorce		Year or Dat	es:	16a Dooga	ent's Usual O	locupa	tion		16h	Kind of Bus	Whi	
5	c • 👼 🗦	Sec	(Specify only high	est grede	completed)		(Give	kind of work of OO NOT use r	done d retired)	uring most of work	ing				
212	y within jiane.	E	Elementery/Secondary (0-12)		College (1-4		Nur						-		Community of Charity
	be filed withintal Hygiane. d other than event, the M		17. Father's Neme (First, Middle	, Last)						18. Mother's Name	e (First, Middle				1 Marity
<u>la</u>	Manta Marked		John Dugan							Aloysia	Reckne	er			
Maryland	12 should be filed v h and Mantal Hygia f is marked other t raumatic event, th		19a. Informant's Name/Relation							nd Number or Rure				State, Zip	Code)
	and m 27 her tr	-	Sister Camil	Avenue,	Emmitsb Date		·	217							
Baltimore,	parmit. Peges 1 and 2 should Department of Health and Mar Important: if Item 27 is marke any injury or other traumatic once.		20a. Method of Disposition 1 🖔 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)									20c. 1	Location - C	City or To	wn, State
tim	Parity In		4 Donetion 5 Other (ST. JOS				5/2006				MD. 21727
Bal	pamit. Peges Department of Important: if it any injury or o		21. Signature of Funeral Service	Licensee	00.1	1		. Name and A		Dic.	ILES FU				7 0407
		4	John 1	n.	SRile	2				N ST., E			MD	21/2	
			23a. Part Enter the disease, or shock, or heart failure. Lis	r complica t only one	ations that cau cause on eac	ised the deat th line.	h. Do not ente	er the mode of	f dying	, such as cardiac o	or respiratory e	rrest,			Approximate Interval Between Onset and Death
	Physician /Medical	1	Immediate Cause (Final			2				7	7			t I	2 1 0
	Examiner		disease or condition resulting in death)	a_	Isol	rom	or as a conseq	idio	in	Japa/	Ley			i-	LYU!
-	<u> </u>	<u>.</u>			4.0	Due to (c	or as a conseq	uence or):						Ē.	4000
V	ificate be executed g physician and as the bunal-trensit		Sequentially list conditions.	b	TY	Due to (c	or as a consequ	uence of):						3	7 (10
Ő,	a exe	֡֜֜֜֞֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֡	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	J .										İ	
68760,	ata b shysic the b	3	that initiated events resulting in death) Last	C		Due to (o	r as a consequ	ence of):							
				d.										1	
Box	eath cert ettendin for use														
P.O.	The law requires that the death cent sate has been signed by the ettending page 2 should be deteched for use a Completed by Physician/M	2	Part II. Other eignificant conditi	one contri	ibuting to deat	h but not res	ulting in the un	derlying caus	e give	n in Part I.	1				the cause of death?
	that		Anomia								10	Yes	2 ℃ No	3 ∐ Prot	pably 4 ☐ Unknown
Řecords,	quiras in sign uld be	3	01 - 0	,		/					24a. Was		opsy	24b. We	ere autopsy findings atlable prior to
ပ္တ	s been si 2 should		collapse	d	leg-	les	uf.	- 4			pend	ormed?		CO	mpletion of cause death?
	The law te hes bage 2		V				0				10	Yes 1	UNK	10]Yes 2□ No
of Vital	certificate rector, pag		25. Was case referred to medica	at						26. Place of Death	(Check only	one)			
Ž	this ce al dire		examiner? 1 ☐ Yes 2 ☒ No	Ho	spital: 1 □ Inp	atient 2	ER/Outpatient	3□ DOA	Othe	r: 4 🖾 Nursing Ho	me 5□Resi	dence	6 □Other	(Specify	1)
0	Attending Physician: or death. ector: After this certific by the funeral director.	5	27. Manner of Death 1 ᠒ Naturel 5 ☐ Pendi	ng	28a. Date of (Month,	Injury <i>D</i> e <i>y</i> Yea <i>r)</i>	28b. Time of Injury		Injury Work		28d. Describe	how inj	ury occurre	d	
sio	tendi seath tor: A the f	5	2 ☐ Accident invest 3 ☐ Suicide 6 ☐ Could	igation not be				М		es 2 No	006 1	0	-141 - 1 -		(Davids Marchael
Division	or At after c Direct in by		4 ☐ Homicide determ		28e. Plece of building	Injury - At ho , etc. (Specif	ome, farm, stre	et, factory, of	fice		City or To			r or Hura	I Route Number,
	ours gerail	-	29a. Certifier 1 Certifyi	na Physic	lan: To the he	est of my kno	wledge deeth	occurred at the	ho time	e, date end place,	and due to the	cause(s) and man	nor as st	eted
	To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com		(Check only 2 Medical one)	Examine	r: On the basi and manne	s of exemina	tion end/or inv	estigation, in	my opi	nion, death occurr	ed at the time,	date ar	nd place, er	nd due to	the cause(s)
	within To the comp		29b. Signature end title of certifie	er			^	29c. Li	cense	number		29d. D	ate signed	(Month, I	Dey, Year)
			Bartes	16	Dens.	000-	Bite	El Da F	10	chho	37	MA	RCH 1	3, 2	306
	Ú		30. Neme end address of person	who com	pleted cause	of death (Item	1 23e) (Type, F	Print)		121-17	368	287	Ma	2 Li	STRE81
	1		ISONITA J.	KRE	in PE	C- f	ORT 10	ERDO	7 E	Elma	178B6	iRo	P, U	ID!	2()2)
	State Registrar		31. Dete filed (Month, Dey, Year,		32. Reg	istrer's Signa	ature								,
	negisti ai		MAR 1 7 2	DOC	May .	10	A	F .							

ORIGINAL

DHMH 16 Rev 6/95

			1 - For State	State of Maryla		ment of H			0000	09224
			Registrar 1. Decedent's Name (First, Middle, Last)		Oeran	icale of I	Dealli	2. Date of Deat	eg No U	3. Time of Death
П	Physici		EVELYN R.	DUNCAN				Month 03	Day Year 06 200	
	/Medic Examir		4a. Facility Name (If not institution, give s		4b	. City, Town, or	Location of Death	1	4c. County of Dea	
	LAGITIII		SUNSHINE ACRESAL	F 4970 Jour	ACRESP	Win	ITE HA	166	Harfor	rd
	Funeral		5. Social Security Number 6. Sex			Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		rthplace (State or Foreign ountry)
	Director		100-12-7000]M 2 ☑ F	86 Yrs.	July 5	110033 14111.	July 19		Maryland
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Location	on				10d. Inside City Limits
	Maryl f ehc	ŏ	MD Harfor		Total di Li	TT = 1 1				1 ☐ Yes 2 ☑ No
	128e	Director	10e. Street and Number	a	White	Of. Zip Code		1	0g. Citizen of What C	ountry?
	h with	ai D	2664 Jolly Acre	s Road		21	161		ŪSΑ	
	deat	Funerai		12. Was Decedent Ever in U Armed Forces?		Decedent of H	ispanic Origin? (S in, Mexican, Puert	pecify Yes or No-	14. Race - Am	
36	or ite	y Fu	1 Never Married 2 Married	1 Tes 22 No		yes 2√2 No	Specify:	o moan, etc.)	Black, Whi	ite, etc.
ő	uret,	d by	3Ã Widowed 4 □ Divorced	Year or Dates:						White
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-f ehow ite Medical Exercit or traust be notified at	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Decedent's (Give kind	s Usual Occupa Fof work done o VOT use retired	during most of wor	king	16b. Kind of Business	/Industry
12	iene.	E O	Elementary/Secondary (0-12)	College (1-4or 5+)		d Serv	•		Public S	School
ğ	Hygid other	BeC	17. Father's Name (First, Middle, Last)	-				ne (First, Middle, M		Denoor
ılar	uld be Menta rrked ritic ev	To B	Jacob Franklin	Rutledge		ı	Agnes	Orsbur	cn	•
Maryland	2 should be finand Mental I is marked of reumatic eve		19a. Informant's Name/Relationship (Ty)	ое, Print)	19b. Mailing Ad	ddress (Street a	and Number or Ru	ral Route Number,	City or Town, State,	Zip Code)
	0 =		Carolyn D. Morr	is/Daughter	r2664 J	olly A	cres Ro	ad Whit	e Hall,	MD 21161
Ore	Pages 1 nent of H int: if ite		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ R					ch 9,	20c. Location - City or	Town, State
Baltimore,	t. Pa ntmen ntsnt:		4 □Donation 5 □ Other (Specify)	Met	cemetery, cremato Crisvill Chodist	Cemet	ery 20	06	White Ha	ill, MD
Bal	permit. Pages 1 an Department of Heal Importsnt: if Item 2 any Injury or other once.	1517	21. Signature of Augeral Service Licente	Jan Val	22. Na	me and Addres	J.	J. Hart	enstein 1	Mortuary, In
			23a. Part 1. Enter the disease, or compli	cations that caused the dea	PANNET 2	o. Mar	n Stree	t Stewa	ırtstown,	PA 17363 Approximate
	Dhusisian		Immediate Cause (Final	e cause on each line.	, .		9, 000	or roophatory arro	,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consec	Hon					days
	Examiner			Dychhesi	4 d					24000
	D ==	ner	Sequentially list conditions, but any, leading to immediate cause. Enter Underlying	Cua to for as a consec	quence of):					
	acute	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	COA						ylens
8760,	cate be executed physicien and the burial-transit	E	vosaling in dealiny East	Due to (or as a consec	quence of);					,
387	The law requires that the death certificate be executed te has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dical	d							
× 6	eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregn	ancy				22d Date of de	line
Box	atter d for u	clar	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3 Ecto	opic pregnancy ner (specify)			23d. Date of de Month	Day Year
<u>о</u> .	that the de led by the a detached t	hys	9 Unknown	9□ Unknown		,.				
	res tha igned be del	by Physician/Me	Part II. Other significant conditions con	tributing to death but not res	sulting in the underl	lying cause give	en in Part I.	23e. Did tob	acco use contribute to	o the cause of death?
ğ	w require been sig		Drog thomas					1 ☐ Ye	s 2 XNo 3□P	robably 4 []Unknown
Records,	hes be	Completed	Dementia.					24a. Was ar		utopsy findings available completion of cause of
		Sol						perform 1 ☐ Yes 2	ned? death?	L-:
Vital	ysician: The is certificate he director, page	Be	25. Was case referred to medical examiner?	a saital:		104		th Check only one	a)	Accelot
	£ ≅ ≅	2	1 Yes 2 No	ospital: 1 Inpatient 2 28a. Date of Injury	ER/Outpatient 3 28b. Time of	DOA Othe	4 Nursing H	ome 5 Reside		poity) 25515 Fect
0	ding th. After	ţ	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	28c. Injury Work	res 2 □No	28d. Describe ho	w injury occurred	
Division of	Atter r dea ector by the	Ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At h	ome, farm, street, f			28f. Location (Str	reet and Number or R	ural Route Number,
	s effe et Dir ed in	Certification:	4 Normicide	building, etc. (Special	fy)			City or Town	, State)	
	toepil thour uner uner		29a. Certifier 1X Certifying Phys	ician: To the best of my know: On the basis of examina	owledge, death occ	curred at the tim	e, date and place,	and due to the ca	use(s) and manner as	s stated.
	To the Hospital or Attending Physician: which 24 hours state death To the Funerel Director: After this certifical completely filled in by the funeral director.	Medical		and manner stated.						
	5.45.9	-	29b. Signature and title of certifier	mo		29c. License		29	d. Date signed (Mont	n, Day, Year)
1	1		20 Nome and addition		- 00-\ /T = 0				3/4/06	
			30. Name and add ess of person who con	mpleted cause of death (Iter	in 23a) (Type, Print	a POA	Ste 201	84 Parks	10, Ma 210	234
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	1-00			*	
	Ponictr		594 SELPC (/ / 1111/5)	7 1 19 N 19 19 19 19 19 19 19 19 19 19 19 19 19	ALTERNATION OF THE STREET					

Dh		negistrar AMEND#23a(b)r Decedent's Name (First, Middle, La		HAM'MQ	D 061	cate (of Death] :	2. Date of Deat Month		Year	3. Time of Death
Physic Medi/	cal	Herman B. Direc								ry 21, 2	2006	6:45P
Exami	ner	4a. Facility Name (If not institution, gi	e street and numbe	9r)			vn, or Location of			4c. County of		
uneral		2619 Colston Dr 5. Social Security Number 6.3	Sex 7.	Age (In yrs.	last birthday)	If Under 1 Y		24 Hrs.	B. Date of Birth	Mont	gome 9. Birth	ery place (State or Forei ptry)
irector		356-09-5276	1 XM 2 □ F	89	Yrs.	Months Da	ays Hours	Min.	(Month, Day, Feb 24			inois
*		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						0d. Inside City Limi
f eho	ō											1 X Yes 2 □ N
"natural", or iteme 23a or 28a-f show solical Evandian must be notified at	Director	Maryland Montg 10e. Street and Number	omery	C1	hevy Ch	10f. Zip Co	de		1	0g. Citizen of W	hat Cour	ntry?
23a o	aiD	2619 Colston Dr					20815			USA		
	Funerail	11. Marital Status	12. Was Decede Armed Force	s?		Was Decedent f Yes, specify (of Hispanic Orig Cuban, Mexican	gin? (Spec	ify Yes or No- ican, etc.)	14. Race	- Americ	an Indian,
0	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes, Give Year or Date	X No. ,,,	WII 1	I□Yes 2🙀	No Specify:			Specify:	,	
a a	edt	15. Decedent's E		S. 771		lent's Usual O	rcupation			16b. Kind of Bus	iness/In	White
-	Completed	(Specify only highest gr Elementary/Secondary (0-12)		or 5.4\	(Give	kind of work do	one during most	t of working	7	TOO. INSIG OF DAG		austry
6.9	E	Lienteritary/Secondary (0-12)	College (1-40	4	Eco	nomist				Feder	al (Governmen
d other	Be (17. Father's Name (First, Middle, Last	")				18. Mothe	r's Name (First, Middle, M	Aaiden Sumame)	
ie marked eumatic ev	ပ္	Abraham Directo	_					a Cho				
importent: if item 27 ie marked eny injury or other treumatic e once.		19a. Informant's Name/Relationship			1					City or Town, S		Code)
Par S	1	Betty Director/ 20a. Method of Disposition	Wife	20b. F	Place of Dispos	sition (Name o	of	hevy Da		MD 2081 20c. Location - C		wn State
# 5h	1	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		.19	cemetery, crem	•		Tr.L				
injur	!	21. Signature of Funeral Service Lice		31)6 Olne 1di Fune		
E & g		1 alas	Oa	200								поше , MD 208
		23a. Part1. Enter the disease, or comshock, or heart failure. List grily	lications that caus	sed the deat								Approximate Interval Between
sician		Immediate Cause (Final disease or condition)				atory A				1	Onset and Death
edical miner		resulting in death)	Due to (or	as a conseq		respira	atory A.	TIESC				
mmer	_	Sequentially list conditions,	b		Dement	tia						
nsit	niner	Sequentially list conditions, if any, leading to infiniadiate cause. Enter Underlying Cause (Disease or injury	Due to (at	as a conseq	uanta of).							
sician and burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or	as a conseq	uence of):						-	
	cal		d									
ig ph) as th	ed		_ 0.									
attending phy I for use as th	by Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor			Ectopic pregna	ancy			23d. Date		*
he att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant	at time of d		Other (specif)				Mont	h	Day Year
ned by the a detached f	Phy	9 ☐ Unknown Part II. Other significant conditions			ulting in the un	darh inn on in	annan in Boot t		23a Did tah			and the second
50	d by	Tarrii. Other significant contactors	contributing to death	i but not res	diding in the un	idenying cause	given in Fan i.		ll		oute to ir I □ Prob	ie cause of death? ably = 4 ₩Unknov
s peed s	ete											Λ
page 2	Completed								24a. Was ar autops perform	v pr	or to cor ath?	psy findings availat npletion of cause o
ector, pa	ŏ	25. Was case referred to medical					26 Place	of Dooth		₩ No 1L	Yes	2□ No
direct	ToB	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	atient 2 □	ER/Outpatient	3□ DOA	Other		Check on vone e 5⊷ Reside	nce 6 □Oth <i>e</i> r	(Specifi	<i>(</i>)
After this certific funeral director,		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Ir		28b. Time of Injury		Injury at Work?			w injury occurred		/
or: Al	atic	2 ☐ Accident investigation	n		,,		1 ☐ Yes 2 ☐ N	No				
Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of	Injury - At ho	ome, farm, stre	eet, factory, off	ice	28	f. Location (Str City or Town	eet and Number , State)	or Rura	l Route Number,
To the Funeral Directompletely filled in by		200 Contine 1 Contine B										
Funeral etely filled	Medical	29a. Certifier (Check only one) 1. Certifying Pl 2 Medical Example one)	nysician: To the be miner: On the basis and manner	of examina	wledge, death tion and/or inv	occurred at the restigation, in r	ne time, date and my opinion, deat	d place, an h occurred	d due to the ca I at the time, da	use(s) and man ite and place, an	ner as st id due to	ated. the cause(s)
To the complet	Mec	29b. Signature and title of certifier	and manner	Stated.		29c. Lic	ense number		29	d. Date signed	(Month, i	Day, Year)
0		Dan S	1 mg				D148	222		-		
V		11111000		f dooth (lto-	n 22a) (Tunn (Deint)	D148	004		reprua	су 2	2, 2006
		30. Name and address of person who	completed cause of	r death men	I ZORI LIVDE P	-LILIT)						

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

DEMENT

EUGENE

NORMAN

32. Registre's Signature

2006▶

			For State Registrar	State of Maryl		artment of F			ene () () 6	08228
	Physici /Medic	al	1. Decedent's Name (First, Middle, Las	Dibb	le	Ab City Town	a Location of Doub	2. Date of Death Month	Day 200	6 1023 M
	Examin Funeral Director		090-42-0011	udel Ger	yrs. last birthday) 61 Yrs.	23	r Location of Death AD 11 3 If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 18		Thplace (State or Foreign Country) Germany
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County MD Anne A		. City, Town or Lo		polis			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the 23e or 28	al Direc	10e. Street and Number 940 Aqua Court			10f. Zip Code 21	409	10	og. Citizen of What C	•
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show any injury or other treumetic event, the Mudical Eria" in at finial terrolling an once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:	in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 2 No	lispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
Maryland 21215-0036	d within 72 ho piene. r then "netur the Mudical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occup o kind of work done DO NOT use retired lege Pro:	during most of workir d)	ng 1	6b. Kind of Business UMBC and College I	U of MD,
/land ?	uld be filed Mental Hyg Irked othe Itic event,	To Be C	17. Father's Name (First, Middle, Last) Horst Vorspreche				18. Mother's Name Margath		faiden Sumame)	
Mary	and 2 should ealth and Men m 27 is marke her treumetic		19a. Informant's Name/Relationship (William J. Dibbl.				and Number or Rura urt, Annap			Zip Code)
Baltimore,	Pages 1 ament of Hectent: If item		20a. Method of Disposition 1 □ Surial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Specify	Removal from State	b. Place of Dispo cemetery, cre MD Vete	position (Name of matory or other place erans Ceme	etery Feb	27, 2006	Oc. Location - City o	le, MD
Ball	permit. Departr Importe any inje		21. Signature of Foreral Service Licer	ALL	2	2. Name and Addre Barranco 495 Gov.	& Sons, P Ritchie H	.A. Seve	rna Park rna Park,	Funeral Home MD 21146
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	Priose sequence of):		ng, such as cardiac o		•	Approximate Interval Between Onset and Death
8760,	icate be executed physician and s the burial-transit	dical Examiner	If any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last	c	sequence of):			_		
.O. Box 6	ath certif ttending or use as	by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy	1		23d. Date of de Month	Blivery Day Year
Ω.	quires that the de n signed by the a uld be detached f		Part II. Other significant conditions of	ontributing to death but not	resulting in the u	ınderlying cause giv	en in Part I.		acco use contribute t	to the cause of death?
Vital Records,	ysicien: The law requir Is certificate has been si director, page 2 should	Completed						24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of s 2 \sum No
	nysicien: Th	To Be	25. Was case referred to medical examiner? 1 Yes 2 \(\subseteq \text{No} \)	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3 DOA Oth	26. Place of Death er: 4 Nursing Hon		nce 6 □Other (Sp	ecity)
Division of	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely illied in by the funeral director,	Certification:	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not by			M 1 🗆	Yes 2 No		w injury occurred eet and Number or F	Rural Route Number
<u>≥</u>	urs after arel Dire		4 Homicide determined	building, etc. (Sp	pecify)			City or Town,	State)	
	the Hospin 24 hother Function Plately functions	Medical	(Check only one) 22 Medical Exam	ysician: To the best of my niner: On the basis of exam- and manner stated.	knowledge, deat	vestigation, in my o	pinion, death occurre	ed at the time, da	te and place, and du	e to the cause(s)
)	To To	~	29b. Signature and title of certifier	Afra,	mo	DO	6054	29	ad. Date signed (Mon	in, Day, Year)
			William &		(Item 23a) (Type,	6.95	Most Amer	rica	2103	5
**	Sta Registr		31. Date filed (Month, Day, Year)	32. Redistrar's S	ignature	fore				

John Paul Derry 06-1490 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	For State Registrar			epartment of F Certificate of		Re	g. No;2 0 0 1	5 08230
	sicia edic	_	1. Decedent's Name (First, Middle, Las John Paul	Derry				2. Date of Death Month February	Day Yes	3. Time of Death 6 2:40 P M
	mine		4a. Facility Name (If not institution, give Route 662 & Rabbi		ad	4b. City, Town, o Longwood	r Location of Death	1	4c. County of De Talbo	
Fune Direc			219-00-0194	ex 7. Age K∑M 2□F	(In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day 7/28/19	9. 8 957	Birthplace (State or Foreign Country) Maryland
aryland show		_	Usual Residence of Decedent 10a. State 10b. County Maryland Wicom		10c. City, Town o					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
ith the Mi	S DOUBLE	Directo	10e. Street and Number		Salis	10f. Zip Code		10	g. Citizen of What	<u> </u>
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heath and Mental Hygiene. Important: If tem 27 is marked other than "naturel", or items 23a or 28a-f show within to any 1		by Funeral Director	31004 Nassawango 11. Marital Status 1 Xever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ₺ N If Yes, Give Year or Dates:	ever in U.S.	2180 13. Was Decedent of H If Yes, specify Cuba 1 Yes 2X No		pecify Yes or No- p Rican, etc.)	USA 14. Race - A Black, W Specify:	merican Indian, hite, etc. white
72 hou			15. Decedent's Ed (Specify only highest gra	ucation	(6	ecedent's Usual Occup live kind of work done te. DO NOT use retired	durina most of worl	king	6b. Kind of Busine	ss/Industry
ed withir ygiene.	B 100	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	echnician	·		Hydraul	ics
uld be fill Aental H rked oth	- A	To Be	17. Father's Name (First, Middle, Last) Norman Vincent	Derry				ne (First, Middle, M ne Chicor		
nd 2 sho	Itanua		19a. Informant's Name/Relationship (7) Diane Lynn Trice,			ailing Address (Street				
Pages 1 ar	y or other	1	20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	20b. Place of D cemetery. WiCOMIC	sposition (Name of crematory or other place of Memoria)	(8)	Date 2	Oc. Location - City Salisbur	or Town, State
permit. F Depertme	SDCe.	Ì	21. Signature of Funeral Service Licen		Park	22. Name and Addre	ss of Facility Funeral	Home Prof	essional	Association
			23a. Part1. Enter the disease, or compshock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not		g, such as cardiac			Approximate Interval Between Onset and Death
Physici /Media Examir	cal		disease or condition resulting in death)	a. Due to (or as a	consequence of):	2 inge	nes			
		edicai Examiner	Samentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	consequence of):					
ficate be expression of the business of the bu	DO BUS	edicai		d						
The law requires that the death certificate be executed at has been signed by the attending physicien and area 2 should be described for use as the buried transit	900000000000000000000000000000000000000	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 3 4 □ Pregnant at 1 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of Month	delivery Day Year
w requires that been signed by	alan an nin	ক	Part II. Other significant conditions of	ontributing to death bu	t not resulting in th	e underlying cause giv	en in Part I.	23e. Did toba	4	to the cause of death? Probably 4 □Unknown
The law retained at the la	v l	Completed						24a. Was an autopsy perform	ed? prior death	autopsy findings available o completion of cause of ?
sician: certific	i acioi	o Be	25. Was case referred to medical examiner?	Hospital:		tions all post oth	or	th (Check only one		at goong
To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha	ם ומוופודים	$\vdash_{\mathbb{R}}$	27. Manner of Death 1 □Natural 5 □ Pending 2 ★Accident Investigation	28a. Date of Injur (Month, Day 2/26/0	y 28b. Tim	e of 28c Injur	4 Nursing H	28d. Describe how De Casto and fu	w injury occurred	opecity) at scene of truck-struck
urs after de	iled iii by	Certification;	3 Suicide 6 Could not be determined	building, etc	. (Specify) VOQ	street, factory, office		28f. Location (Stre City or Town, Reublot##ill	State) Route State) Route TEd. Longsv	
HOSE 124 hou Fune	ingleis i	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one)	ysician: To the best o liner: On the basis of and manner star	examination and/o	eath occurred at the tin r investigation, in my o	ne, date and place, pinion, death occur	, and due to the car rred at the time, da	use(s) and manner te and place, and c	as stated. lue to the cause(s)
To th withir		Me	29b. Signature and Ittle of certifier	hy	h	29c. Licens	e number		d. Date signed (Mo	
68	S		30. Name and address of person who	complete use of de	ath (Item 23a) (Ty	pe, Print) 1 Penn Str	eet, Balt	timore, M	aryland	21201
Reg	Stat gistra		31. Date filed (Month, Day, Year) MAR 0 3 2		r's Signature	Board .				
DHMH 17 Re	v 1/20	01			1				2.55	

DHMH 17 Rev 1/2001

ORIGINAL

			Please	Obstant Manual				
			1 _ For State	State of Marylan				9006 00931
			Registrar		Centica	te of Death		OU COM.
	Physicia	an	1. Decedent's Name (First, Middle, La.	st)			2. Date of Death Month	Day Year 3. Time of Death
	/Medic		100 D45h	1611	1 // 00	Ŧ	march	4c. County of Death
À.	Examin	er	4a. Fecility Name (If not institution, giv			y, Town, or Location of Death		1
			HNCHORAGE N		ME	OALISBURY er 1 Year If Under 24 Hrs.	8. Date of Birth	WICOMICO 9 Birtholace (State or Foreign
	Funeral		5. Social Security Number 6. S 213-14-6243	□M 2×F 8/	Yrs. Month:		(Month, Day,	Year) 9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	0			J 2	7
	yland yland		10a. State 10b. County	10c. Cit	y, Town or Location			10d. Inside City Limits
	Mar at at	to	MD Wice	onico	SAL15	BURY		19 Yes 2 □ No
	or 28	Director	10e. Street and Number	-	10f. 2	ip Code	10	g. Citizen of What Country?
	th will		1106-WES	T KOAD		21801		USA
	eme eme	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13. Was Dec	edent of Hispanic Origin? (Secify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	or It	by Fu	1 Never Married 2 Married	1 □Yes 2 No If Yes, Give	1 ☐ Yes	2 No Specify:		Specify: RIASK
21215-0036	d within 72 hours after death with the Maryland Jione. I than "natural", or Iteme 23a or 28a-f ahow The Medical Exaciliner count be notified at		3 Widowed 4 □ Divorced	Year or Dates:	16a. Decedent's Us	ual Occupation		16b. Kind of Business/Industry
5	"naf	Completed	15. Decedent's E (Specify only highest gra	ide completed)	(Give kind of v	vork done during most of wor		ob. Rind of Susmossmansing
12	within ene. than "	щo	Elementary/Secondary (0-12)	College (1-4or 5+)	DO	MESTIC		ANDERTON FAMILY
9	other ent.	0	17. Father's Name (First, Middle, Last				ne (First, Middle, M	faiden Sumame)
lan	thould be id Mental marked c	To B	LONNIE -	BURRIS		HNR	115 (7)	REENE
Maryland	2 should and Men is marks sumatic		19a. Informant's Name/Relationship (19b. Mailing Addre	ss (Street and Number or Ru	ral Route Number,	City or Town, State, Zip Code)
-	ges 1 and 2 should be filed tof Health and Mental Hyg If Item 27 is marked othe or other traumatic avent,		ADA DUNTON.	~DAUGHTER	28175	- ALLEN CUT	OFF KD.	EDEN MD 21812
Baltimore,	of He		20a. Method of Disposition 1' Burial 2 ☐ Cremation 3 ☐		Place of Disposition (Acemetery, crematory of	ame of rother place)	Date 2	20c. Location - City or Town, State
Ĕ	nit. Pages artment of ortant: If It injury or o		'4 □Donation 5 □ Other (Special		DWERHILL	CEM 319	006	EDEN, MD
alt	permit. Pag Department Important: any injury conce.		21. Sign ure of Funeral Service Lice	nsee (22. Name	and Address of Facility	BENNIE	SMITH F(H
<u>m</u>	Dep Imp		Muscul	la Found	N 1917-1	N.LSABELLA	ST. SA	KUSBURY MD 21801
- 54			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat one cause on each line.	th. Do not enter the m	ode of dying, such as cardia	or respiratory arre	Approximate Interval Between Onset and Death
15	Physician		Immediate Cause (Final disease or condition	RANAL	FAILURE			Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq	quence of):			
	Examiner		Sequentially list conditions, if any, leading to immediate	6. BREAST	CANCER			
	sit ad	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	-	Low		
	be executed ician and burial-transi	хап	that initiated events resulting in death) Last	c. Lue to (or as a conseq	1BRILLAT	INV		
760,	be executed sician and burial-transit	alE	l					
687	physicate sthe	dic		d				
Box (eath certificate attending phys I for use as the	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna				23d. Date of delivery
	atter d for u	clar	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d				Month Day Year
P.O.	the c by the	nysi	9 Unknown	9□ Unknown				
	The law requires that the death certificate ate has been signed by the attending physogge 2 should be detached for use as the	by P	Part II. Other significant conditions	contributing to death but not res	sulting in the underlying	g cause given in Part I.	23e. Did tob	acco use contribute to the cause of death?
ğ	w require been sig should b						1 □ Ye	s 2 ☑No 3 ☐ Probably 4 ☐Unknown
တ္တ	aw re	plet					24a. Was ar	
of Vital Records,	The lav	Completed					perform	ned? death?
ital		Be C	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one	*
1	Physicien: r this certificated rail director, i	2	1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing I	lome 5 ☐ Reside	nce 6 Other (Specify)
	fter th		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe ho	w injury occurred
Ö	Attending it death. ector: After by the fune	catic	2 Accident investigation		М	1 ☐ Yes 2 ☐ No		
Division	or Attendate death Director:	Certification;	3 Suicide 6 Could not to determined		ome, farm, street, fact fy)	ory, office	28f. Location (Sti City or Town	reet and Number or Rural Route Number, r, State)
	itel c		1					
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edica						iuse(s) and manner as stated. ate and place, and due to the cause(s)
	the thin 2 the mplei	Med	29b. Signature and title of certifier	and manner stated.	1:	29c. License number	25	9d. Date signed (Month, Day, Year)
	To To	_	1 Danie	MIZ		D63433		3/2/1.
			20 Name and address of a second		m 23a) (Tuna Drint)			7/14
			30. Name and address of person who	Completed cause of death (Itel	TRA	4117 504B	SAUSBU	RY MD 2130 4
	St	ate	31. Date filed (Month, Day, Year)	32. Begistrar's Sign	ature		1 - 1 - 1 - 1 - 1 - 1 - 1	
	Regist			2006	K bores			

				State of Maryland	/ Departmer	t of Health and I	Mental Hygier	ne	
		-	For State Registrar	,, ,,		e of Death	Reg. I	2000	08232
	Physici /Medic	al	Decedent's Name (First, Middle, La ONZO 4a. Facility Name (If not institution, gi	Washington		more Town, or Location of Death	February	Day Year 20, 2006 4c. County of Deat	3. Time of Death
	Examin Funeral Director	GI	Peninsula leg 5. Social Security Number 6.	ional medical diseases 7. Age (In yrs. last	enter 3	1 Year II Under 24 Hrs. Days Hours Min.		Wicon 9. Birt	
	Maryland a-f ehow	tor	10a. State 10b. County	De De	own or Location	₩10°			10d. Inside City Limits 1 🔁 es 2 🗆 No
	hours after deeth with the Maryland tural', or Iteme 23a or 28a-f ahow al Esaminer must be notified at	Funeral Director	10e. Street and Number 11388 STewar 11. Marital Status		rd c	o Code 21853 dent of Hispanic Origin? (Sorty Cuban, Mexican, Puert		L.S. F	erican Indian,
9000	nours after ural', or Ite	by	1 Never Married 2 Married 3 Widowed 4 Privorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes	2 ✓ No Specify:		Specify: Specify:	lack
21215-0036	within 72 ene. than "na:	Completed	15. Decedent's E (Specify only highest gi			ork done during most of wor		hicken	PlanT
Maryland 2	be filed tal Hyg od othe event,	To Be C	17. Father's Name (First, Middle, Las	E MORES.		Peach	ne (First, Middle, Maid	ia Ste	evenson
_	es 1 and 2 and 2 of Health ar		19a. Informant's Name/Relationship Lath Lath Elmo € 20a. Method of Disposition 1 ⅓ Burial 2 □ Cremation 3	2 Sr./500 20b. Place		other place)	Date 20c.	Location - City or	ne MD 21853 Town, State
Baltimore,	permit. Pages Depertment of I Important: If It eny Injury or o		4 Donation 5 Other (Spec	(h) John	Wesley 2. Nam a	nd Address of Facility	Funeral	Home Home	Anni MD MD 21853
	Physician		23a. Part1. Enter the disease, or co- shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	nplications that caused the death. If y one cause on each line STATUS		de of dying, such as cardial	or respiratory arrest,		Approximate Interval Between Onset and Death 45 MIN.
	/Medical Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequent ENCEPHA) Due to (or as a consequent	LOPATI				10 DA43
,092	icate be executed physicien and s the burial-transit	Ical Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. ALCOHOLI Due to (or as a consequen		er Dise	ASE		ZYEARS
O. Box 68	The law requires thet the death certifica ate has been signed by the attending ph page 2 should ba detached for use es th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 Ectopic			23d. Date of de Month	livery Day Year
ds, P.O.	puires thet t n signed by uld ba deta	þ	Part II. Other significant conditions	contributing to death but not resulting	ng in the underlying	cause given in Part I.	23e. Did tobacc		o the cause of death?
Il Records,	The law require	Completed					24a. Was an autopsy performed 1 ☐ Yes 2 ⊡	24b. Were at prior to death?	utopsy findings available completion of cause of
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 (Mapatient 2 ☐ ER	NOutpatingt 2 F	Other	ath (Check only one) Home 5 ☐ Residence	6 □Other (Soc	entr)
õ	ng Har		27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Year) 28	Bb. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how in		neity)
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not determine	d building, etc. (Specify)			28f. Location (Stree City or Town, St	tate)	- American de Constantino de Constan
	Hosp 24 hou Fune etely fi	Medical	29a. Certifier 1 Certifying I (Check only 2 Medical Ex-	Physician: To the best of my knowle miner: On the basis of examination and manner stated.	edge, death occurre n and/or investigatio	d at the time, date and place n, in my opinion, death occi	e, and due to the cause urred at the time, date	a(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier		4.7	D 4 6 9 (o 2 FE		26,2006
r			30. Name and address of person wh	o completed cause of death (Item 23	3a) (Type, Print)	, NAL MED.	CAL CEN	STE R.	MD 21801.
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	е				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#23a line b penD 9856.6/29/06 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** March 1, 2005 5:11 June H. Fugate Ри /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Beltsville 11912 Gordon Avenue | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State | Months | Days | Hours | Min. | April 12, 1922 | Mary Land 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 20F 215-14-2679 83 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County rthen "naturel", or items 23s or 28s-f ehow the Medical Examiner must be notified at Maryland Prince George's **Beltsville** 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20705 United States 11912 Gordon Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Marned Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) National Institute College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse of Health permit. Pages 1 and 2 should be filed v
Deportment of Health and Mental Hygie
Important: if Item 27 ie marked other t
any injury other treumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be Griffith HillHarry W. Daisy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1413 Ormsby Place Crofton, Maryland 21114 Susan H. Fugate -daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State Metropolitan Crematory 3/4/2006 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) Donald V. Borgwardt Funeral Home, PA 21. Signature of Funeral Service Licensee / Lorold 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Advanced Ateriosclerotic Cardiovascular Disease 10 years /Medical Due to (or as a consequence of): q months Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine ig physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed 5 vears Chronic Hypertensive Heart Disease resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 5 Other (specify) signed by the a 9 Uaknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown should should 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificete hes t lirector, page 2 s 1 Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\)Other (Specify) ၀ 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) March 2, 2006 29c. License number 29b. Signature and title of certifier D13671 11 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B.G. Manejwala, M.D. 14201 Laurel Park 14201 Laurel Park Drive, #102 Laurel, Maryland 20707 32 Registrar's Signature 31. Date filed (Month, Day, Year) MAR 0 3 2006 Registrar

			For State	State of Manyland	/ Depa	rtment of	Health a	nd Mei		1	116	0823	} [.
	2		For State Registra AMFND#20perMF3/. 1. Decedent's Name (First, Middle, Last)	3/06,BMV,McCo	Cer	uncate of	Dealli	2.	Date of Deat	h Day	Voor	3. Time of Do	
	Physicia /Medic		WILLIAM PADE						Month -	20-	06	2050	Э м
7	Examin	er	4a. Facility Name (If not institution, give s. UNIVERSIM OF M		1/26	4b. City, Town,	or Location of			4c. Co	unty of Deeth		
	Funeral Director		5. Social Security Number 218-40-9192 6. Sex	M 2□F 7. Age (In yrs. las. 63	t birthday) Yrs.	If Under 1 Year Months Day		Min. A	Date of Birth (Month Day Dril 1	¥ , 194	9. Birthp Cour Mar	place (State or F ntry) y Land	Foreign
	land ow		Usuel Residence of Decedent 10a. State 10b. County	10c. City, 1	Town or Lo	cation					1	0d. Inside City	
	e Man Ba-f sh	Director	Maryland Prince Ge	eorge's Beli	tsvil					2	/34	1 Tes 2	XNo
	3a or 2	i Dire	4305 Sarasota Place	2		10f. Zip Code	705		'		of What Cour ed Sta	-	
36	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "naturel", or flems 23e or 28e-f show event, the Medical Exact are must be notified at	by Funerai	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Å No If Yes, Give Year or Dates:	1	Was Decedent of f Yes, specify Cu		in? (Specif Puerto Ric	y Yes or No- an, etc.)		Race - Americ Black, White, ecify: W		
21215-0036	hin 72 hou e. en "nature Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life. L	tent's Usual Occ kind of work don DO NOT use reti	e during most	of working			of Business/In		
N p 5 a 2												Manufac	turi
land	should be fand Mental Is marked of	To Be	John William Fade	e l y				Lou		ay			
Maryland	permit. Peges 1 and 2 should by Depertment of Health and Menta Important: If teem 27 is marked any injury or other traumatic enone.		19a. Informant's Name/Relationship (Type Lacey A. Fadely -will			ng Address <i>(Str</i> e Sarasota							
Baltimore,	not: If New		20a. Method of Disposition 1 Derial 2 Cremation 3 Re			sition (Name of natory or other p		Date			ion - City or To		<u>.</u> _
ıltim	permit. Pe Depertmen Important any Injury once.		*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		-	tan Cren	-					Virgin	
Ä	Der Imp		23a. Part1. Enter the disease, or complishock, or heart failure. List only on	a gward	4	onald V. 400 Powe	der Mil	1 Roa	d Belt	svill	e, Mar	yland 2 Approximate Interval Between	.0705
68760,	Physician: The law requires that the death certificate be executed by the attending physician and properties that been signed by the attending physician and properties that director, page 2 should be detached for use as the burial-transil	dicat Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	nce of):	mens a	ll Cara	ulma	1 06 Na	ad 81	Neck		
P.O. Box 6	the death certific / the attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregnanc 1 □Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3	Ectopic pregnar Other (specify)				230	. Date of deliv Month	ery Day Ye	ıar
	quires that the de n signed by the a uld be detached f	þ	Part II. Other significant conditions con	stributing to death but not resulti	ing in the u	nderlying cause	given in Part I.			bacco use es 2□N		he cause of dea	- 1
Division of Vital Records,	sician: The law require certificete has been si irector, page 2 should I	Completed							24a. Was a autops perfor	v l	prior to co death?	opsy findings av impletion of cau	railable use of
Vita	ician: certific rector.	Be	25. Was case referred to medical examiner?	lospital:	D/O		Ther.		Check only or	_	Othor (Casa)	4.1	
on of	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Annpatient 2 LE	R/Outpatier 8b. Time of Injury	f 28c. in	4 1401	28	d. Describe h		Other (Speci ccurred	(y)	
Divisi	at or Atten after deal Director d in by the	Medical Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	reet, factory, offic	се	28	f. Location (S City or Tow	treet and N n, Stete)	lumber or Rur	al Route Numbe	er,
	ne Hospitu 124 hours ne Funere letely fille	dical C	29a. Certifier Check only one) Certifying Physical Examination	sician: To the best of my knowler: On the basis of examination and manner stated.	ledge, deat on and/or in	h occurred at the vestigation, in m	time, date and y opinion, deat	d place, and	d due to the o	ause(s) an late and pla	d manner as s ace, and due t	stated. o the cause(s)	
	To th Withir To th comp	×	29b. Signature and title of certifier	DR. CHRISTINE HIW	1111	1	ense number	's @	- 2		igned (Month,		
	B		30 Name and address of person who co									4	
			30. Name and address of person who co				ou MI	9 42	01 (VIT	ne Hu	unh, M	.D.
	Sta Regist	ate rar	MAR 0 3 20	32 Registrar's Signatu	A	gue!							

			For State Registrar	State of Marylar		artment of H tificate of L			jiene leg. No.	106	08235
	Dhuaiai		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month 03	oth O4	Year	3. Time of Death
	Physici: /Medic			mer					-	2006	9:40 A M
1	Examin	er	4a. Facility Name (If not institution, give st	treet and number)		4b. City, Town, or	Location of Death	ı		unty of Death	
			Talbot Hospice Hou	1SE 7. Age (In yrs.	la et hirthday)	Easton If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		1bot	place (State or Foreign
	Funeral Director		1 🗆	M 2XF 80	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 04/01/1		Cou	essee
			218-16-9469 Usual Residence of Decedent					104/01/1	723		
	how	_	10a. State 10b. County		ity, Town or Lo	cation				1	1 ☐ Yes 2 XNo
	Ba-f	Directo	MD Caroline	Ri	Ldgely	1				(110)	
	with th		10e. Street and Number			10f. Zip Code				of What Coul	ntry?
	eath v	Funeral	12472 Ridgely Road 11. Marital Status	2. Was Decedent Ever in U	IS 13 1	21660	snanic Origin? (Si	necify Yes or No-		S.A. Race - Americ	can Indian.
	iter d	F	1 Never Married 2 Married	Armed Forces?	i	Was Decedent of H if Yes, specify Cuba		Rican, etc.)		Black, White,	etc.
3	ours after death with the Marylan rai', or items 23e or 28e-1 ehow Execution rount be notified at	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specity:		Sp	pecify: Bla	ck
ည် ၁	tied within 72 hours after death with the Maryland Hygiene. Ither than "natural", or items 23a or 28a-f ehow wit, the Modical Examinant the notified at	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occup	durina most of wor	king	16b. Kind	of Business/In	dustry
7	Athin De h	ldu	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired tician	0		Hair	Salon	
7	be filed within 72 ho ital Hygiene. Id other than "natur event, the Worlder	S	10. Tather's Name (First, Middle, Last)		beau	CICIUII	18. Mother's Nan	ne (First, Middle,			
au	ed at b) Be	Curtis E. Bledsoe				Mary Hat			,	
$\overline{\mathbf{z}}$	d 2 should be th and Mental 7 is marked traumatic ev	ဥ	19a. Informant's Name/Relationship (Typ		19b. Mailir	ng Address (Street				own, State, Zip	c Code)
Σ			Ray Bledsoe / son		2013	Weber DRi	ve; Forr	estville	, MD	20747	
Baltimore, Maryland 21215-0036	S to E		20a. Method of Disposition	20b.	Place of Dispo cemetery, cres	sition (Name of matory or other place	θ)	Date	20c. Locat	tion - City or To	own, State
Ĕ	Pages nent of ant: If it ury or o		1 ■ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)		stern S	hore Vet(em 03/1	0/2006	Hur]	Lock, M	D
a	permit. Page Department of important: If eny injury or once.		21. Signature of Funeral Service License	6		2. Name and Address		ein Fune	ral F	Home. P	'A
	20E = 9		Atpl (1	ly		eegle ₁₆₀					
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	e cause on each line.		•	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	LYNG (ANC	<i>E2_</i>					1 MONTH
	Examiner			Due to (or as a conse	quence of):						
	2	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consc	quanea of):						
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events c.								
ó	e execten and arrial-tr	Exe	resulting in death) Last	Due to (or as a conse	quence of):						
8760	The law requires that the death certificate be executed site has been signed by the ettending physicien and page 2 should be detached for use as the burlat-transit	dical	d.								
ف	eath certific ettending p for use as (IF FEMALE:	3c. If yes, outcome of pregr	ancy				024	d. Date of deliv	-
Box	ettend for us	Physician/Me	in the past 12 months?	1 Live birth 2 Fet 4 Pregnant at time of	al death 3	Ectopic pregnancy Other (specify)			230	Month	Day Year
о <u>.</u>	that the de led by the detached	ıysıc	1 ∐ Yes 2 ⊠ No 9	9 Unknown	30						
	res that igned by be deta	by Pr	Part II. Other significant conditions conf	tnbuting to death but not re	sulting in the u	nderlying cause gıv	en in Part I.	23e. Did to	obacco use	contribute to t	the cause of death?
ra S	w requires been sig should be							1 🗆 Y	′es 2⊡t	No 3□Pro	bably 4 Onknown
Division of Vital Records,	law requas been 2 should	Completed						24a. Was autop		24b. Were auto	opsy findings available ompletion of cause of
ž	The la	E O						perfo 1 ☐ Yes	rmed? 233 No	death? 1 ☐ Yes	
ïta	cian: artific actor,	Be (25. Was case referred to medical examiner?					ath (Check only o			
5	Physician: The la rthis certificete has	10	I I THIS 22 INO	ospital:	ER/Outpatie		4 Nursing r	fome 5 ☐ Resid		·	ty) HOSPICE
UC.	Attending Physician: ir death. ector: After this certifics by the funeral director, i	lon	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Wor	yat k? Yes 2∐No	Zou. Describe i	iow injury c	occurred	
<u>s</u>	or Attendenter death Director:	flca	3 Suicide 6 Could not be	28e. Place of Injury - At	home, farm, st					Number or Rur	al Route Number,
á	≥ 5 t t o	Certification:	4 Homicide	building, etc. (Spec	ify)			City or Tov	vn, State)		
	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	edical (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my kr ner: On the basis of examir and manner stated.	owledge, deat ation and/or in	h occurred at the tire evestigation, in my o	ne, date and place pinion, death occu	and due to the urred at the time,	cause(s) ar date and pl	nd manner as s lace, and due t	stated. to the cause(s)
	To the Vithin To the	Me	29b. Signature and title of certifier		,	29c. Licens	e number		29d. Date s	signed (Month,	
						D0053	815		3/6	1200	6
		1	30. Name and address of person who con	mpleted cause of death (Ite	em 23a) (Type,					/	
			Korah M. Pulimood,			Denton,	MD 21629	9			
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	and the second					
	<u> </u>			1 1 1 1 1	1 34 E. S.	11 60 1 1 F					

			For State Registrar		State of	f Marylan		artment of H rtificate of L		d Mental Hy	giene Reg. No.	006	08236
	Dhirini	7	Decedent's Name (First, Middle	e, Last)						2. Date of De	aath Day	Year	3. Time of Death
	Physicia /Medic	al .	James	Α.		sciocco				Masch		2004	0308 "
	Examin	CI	4a. Facility Name (If not institution	-	treet and nun	nber) CANTU		4b. City, Town, or	Location of D		4c. (County of Deat	
	Funeral		ANINSUIA AGIONIA 5. Social Security Number	6. Sex		7. Age (In yrs.	last birthday	If Under 1 Year	If Under 24 I	Hrs. 8. Date of Bi	th V	9. Birt	hplace (State or Foreign
	Director		178-30-6249	11	M 2□F	68	Yrs.	Months Days	Hours A	11/22/	1937		nsylvania
Ψ,	and w		Usual Residence of Decedent 10a, State 10b. County			10c. Cit	y, Town or L	ocation					10d. Inside City Limits
	Maryli f eho	lor	Maryland Word	este	er	Be	rlin						1 ☐ Yes 2 🔀 No
	n the	irec	10e. Street and Number					10f. Zip Code			-	en of What Co	ountry?
	23a c	ralD	53 High Sherift	Tra	ail			21811				JSA 	
36	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or Itame 23a or 28a-f ehow ent, the Medicel Examinat must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Mar 3 □ Widowed 4 □ Divorced	bei	Armed Fo 1 ☐₩es	2 🗌 No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🕱 No	ispanic Origin' in, Mexican, P Specify:	? (Specify Yes or No uerto Rican, etc.)		4. Race - Ame Black, White Specify: V	
8	2 hours	ted t	15. Deceder	t's Educ	ation	Mari	16a. Dece	edent's Usual Occup			16b. Kin	nd of Business/	Industry
215	thin 7: 8. an "n	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade	College (1	-4or 5+)	life.	b kind of work done of DO NOT use retired	during most of d)	working			
7	led wi	Con	12	(_		Mast	er Plumbe		Name (First, Middle	*		Geriatric
and	ntal H	Be	17. Father's Name (First, Middle, Panfilo Fascio							h Bruno	, Maideri .	<i>Sumanne)</i>	
Mary	d 2 should the and Me to is mark traumatic	ပ္	19a. Informant's Name/Relations Lorraine Fasc.				19b. Mail 53	ing Address (Street) High Sher	and Number o	r Rural Route Numb	er, City or	Town, State, 2 1D 2181	Zip Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: if item 27 is marked other than "natural", or itame 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at once.		20a. Method of Disposition 1 □ Purial 2 □ Cremation 4 □ Donation 5 □ Other (3		emoval from		emetery_cre	osition (Name of omatory or other place oft Cemete	ery 3/	Date 6/06		cation - City or	Town, State ennsylvania
Balti	permit. P Departm Importar any inju		21. Signature of Funeral Service		e Wee	CESP		Olloway 1					ssociation 04
美	Physician /Medical Examiner	Je	23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	complication only on	Due to	ach line. Omogoras a conseq	uence of):	Carcino					Approximate Interval Between Onset and Death One week
68760,	ficate be executed physician and s the burial-transit	edicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	6		or as a conseq							
P.O. Box (The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23	1 Live b	come of pregna irth 2 Peta ant at time of d	I death 3	□Ectopic pregnancy □ Other (specify)	,		2	23d. Date of del Month	livery Day Year
Ś	quires that (n signed by uld be deta	þ	Part II. Other significant conditi	ons con	tributing to de	eath but not res	ulting in the	underlying cause giv	en in Part I.		p .		o the cause of death?
of Vital Record		Completed								24a. Wa. auto perf 1 🗆 Yes		prior to death?	utopsy findings available completion of cause of
/ita	Attending Physician: r death. sctor: After this certification the funeral director.	Be	25. Was case referred to medical examiner?	- t				100		Death (Check only	one)		
_	Physi this o	<u>1</u>	1 Yes 2 No	Н	ospital: 1 28a. Date	npatient 2	ER/Outpatie		4 110131	ng Home 5 Res			icity)
o	ding th. After fune	tion	t ⊠ Natural 5 ☐ Pendi	ng gation	(Mon	th, Day Year)	Injury	Wor	k? Yes 2 □ No		now anjung	, 55541155	
Division	or Attendate deal	Certification:	3 Suicide 6 Could 4 Homicide deter	not be	28e. Place buildi	of Injury - At hing, etc. (Specif	ome, farm, s (y)	treet, factory, office			(Street and own, State)		ural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier 1 Certifyi (Check only one) 2 Medica	ng Phys Exemir	er: On the b	best of my kno asis of examina ner stated.	owledge, dea ation and/or i	ith occurred at the tir nvestigation, in my o	ne, date and p ppinion, death	place, and due to the occurred at the time	cause(s) , date and	and manner as place, and due	s stated. e to the cause(s)
	To the within 2. To the complete	Me	29b. Signature and title of certific	or /		и, О.		29c. Licens				e signed (Mont	
	00		1/2	/ai	T "			03	0690	,	Ma	rah d	2006
\	83		30. Name and address of person	who co	mpleted caus	se of death (Iter	n 23a) (Type	barle	Greot	154.	5.1.	: 5 500	MD,
	Sta Regist		31. Date filed (Month, Day, Year MAR 0	3 20	006	lalus.	H. A	barte					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death . Decedent's Name (First, Middle, Last) February 21, 2006 Physician David Charles Green 2:30 pm M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Prince Frederick Calvert calvert Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. December 24, 1936 Country C Social Security Number 7. Age (In yrs. last birthday) **Funeral X**X M 2□ F 70 Yrs. 578-44-4275 Director Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygene.
Important: if item 27 is marked other than "natural; or iteme 23a or 28a-f show any injury or other traumatic event, the Musical Examinational De notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Calvert Prince Frederick Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 125 Allnut Court Apt 411 20678 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status ☐Xes 2 ☐ No fXes Give rear or Dates: 1 Never Married 2 Married 1 Yes 2 Specify: Baltimore, Maryland 21215-0036 Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Disabled Veteran Government 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Grace Belle Marchion Charles Harrison Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cousin 1620 SE Oak Bend Drive Berryton KS 66409 Lola Warner 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Feb 26, 2006 Clinton, MD Lee Crematory 22. Name and Address of Facility Lee Funeral Home Calvert, P.A 21. Signature of Funeral Service Licensee 8125 Southern Maryland Blvd., Owings, MD 20736 Cary Goff 23a Fant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death inhosis of the Live Immediate Cause (Final disease or condition resulting in death) Priysician 1 COUDIC /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien end for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1/Derten SION 3 Probably 4 □Unknown 1 Tyes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy performed/.

1 Yes 2 No s certificate ha 1 ☐ Yes 2 ☐ No or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death |Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After the 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🗹 Natural 5 Pendina 1 ☐ Yes 2 ☐ No Director: / 2 Accident investigation 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours after To the Funerei Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plane, and due to the names(s) and manner as stated 29a Certifier Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D26007 30. Name and address of person who impleted cause death (Item 23a) (Type, Print) PAUG Fredert MD Goldberr Muspital Pul 110 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 7 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month **Physician** 2006 2:55 A Willard Cornell Griffen, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Worcester Ocean Pines 65 Cresthaven Drive If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ★ M 2 🗆 F Director 077-28-0080 72 4/4/1933 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Peges 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene.
ant: If item 27 ie marked other than "naturat", or items 23a or 28a-f ehow try or other treumatic event, Ita Medical Examinat matter and item and the notified at 1 ☐ Yes 2 XNo Director MD Worcester Ocean Pines 10g. Citizen of What Counfry? 10e. Street and Number 10f. Zip Code 65 Cresthaven Drive 21811 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1952-56 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) 12 Service Foreman Telephone 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willard Cornell Griffen Lucy Flanagan 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Depertment of Health a Importent: If item 27 le any injury or other tret once. 65 Cresthaven Dr., Ocean Pines, MD 21811 Barbara Griffen 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Frankford, DE 4 □Donation 5 □Other (Specify) 3/2/2006 Cape Henlopen Crem. 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William St., Berlin, MD 21811 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) PANCREATIC CHECINOMA **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner attending physicien end for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐ Pregnant at time of death 5 Other (specify) 9 🗌 Unknown Part II. Other significent conditions contributing to death but not resulfing in the underlying cause given in Part I. 23e. Did tobacco use confribufe to the cause of death? ģ ANNO 1 Yes 3 Probably 4 Unknown cete has been sig , page 2 should t Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospitaf: 1 Inpatient Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 Certification: To 2 ER/Outpatient 3 DOA this After this 28a. Dafe of fnjury (Month, Day Year) 28c. Injury af Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, facfory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number

KONALD 31. Dafe filed (Month, Day, Year)

29b. Signature and title of certifier

Begistrar's Signature

KL W

RAVITZ

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 0 3 2006

P

MO 560

D0036576

RIVERSIDE

2/06

DR. SALISB MD 21801

State

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Пач **Physician** OLIVER AWRENCE MARCH 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death VENINSULA LEGIONAL MEDICAL

5. Social Security Number | 6. Sex Examiner Sali Sury If Under 1 Year | If Under 24 Hrs. WICONICO 6. Sex 1 X M 2 □ F 8. Date of Birth (Month, Day, Year) 11-23-1923 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 82 Yrs. 216-14-9209 MD Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "naturel", or iteme 23a or 28a-1 ehow other traumatic event, the Medical Examinar must be notified at WORCESTER **POCOMOKE** 1 XYes 2 ☐ No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21851 WorcestER U.S.A Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★Yes 2 □ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates: 1944-1946 Black 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Schol Bus DrivER Worcester County 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: if Item 27 is marked oth eny julyy or other traumatic event once. Be Dinn Saymond ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SON MO Mitchell 132 rocomoke Date Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

23a. Part. Enter the diseals, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Locomoke, MD 21853 Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit requires that the deeth certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) cete has been signed by the a page 2 should be detached in P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No After this certificete funeral director, pag Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA ŏ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours efter death To the Funeral Director: , completely filled in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitei or Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March 6, 2006 030690 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 32. Registar's Signature Grall ST. 5-1:55007, MD 21801 James E. MARTIN 31. Date filed (Month, Day, Year) State MAR 0 8 2008 Registrar

DHMH 17 Rev 1/2001

Sing

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 28 HURWITZ 2006 5:20 Feb. Jacob /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Mariner Health of Silver Spring Silver Spring Montgomery 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days 1 ☐ M 2 ☐ F Yrs. 83 Apr.20. 1922 Washington, 579-20-3451 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b County or 28a-f show the Medical Ezaminer must be notified at 1 TYes 2 XNo MD Montgomery Silver Spring Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20902 717 Northwood Terrace items 23a Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter important: It item 27 is marked other, the Medical Examinations. 1 Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Manager Newsstand 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph Hurwitz Sarah Walden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lillian Wiseman / sister 717 Northwood Terrace, Silver Spring ND 2090.

Date 20c. Location - City or Town, State ND 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 TxBurial 2 Cremation 3 Removal from State Nat'1. Capital Heb. Cem. 3/1/06 Capital Heights, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Aviga Licenses 22. Name and Address of Facility Torchinsky Hebrew Funeral Home, 254 Carroll St., NW., Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition End Stage Carcinoma of Lung Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No ŏ 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 1 Yes 2 No 3 Probably 4 Minknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No page 1 Yes 2 No certificate Division of Vital the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After **X**Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation the within 24 hours after deat To the Funerel Diractor: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 Suicide à 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umbalicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D52261 Feb. 28, 2006 ren 30. Name and address of person who completed caus of death (tem 23a) (Tipe, Print) 1517 Hugo Cir., Alan R. Segal, MD Silver Spring, MD 20906 31. Date filed (Month, Day, Year) 32 Registrar's Signature MAR 03 5000 Registrar

		1	For State of State and State of Registrar		partment of Health and Nertificate of Death		ene	0021.1
4	Physici	an	Doodent's Name (First, Middle, Lost) RANCES (**A	المحر		2. Date of Death Month		3. Time of Death
	/Medic Examin		a. Facility Name (If not institution, give street and number Renaissance Garden at Riderwood		4b. City, Town, or Location of Death Silver Spring	2	4c. County of Deatl	
	Funeral Director			. Age (In yrs. last birthda 92 _{rs.}		8. Date of Birth (Month, Day, Oct 25,	Year 913 Mas	nplace (State or Foreign untry) SSACHUSETTS
	ס	or	Usual Residence of Decedent 10a. State 10b. County 1aryland Montgomery	10c. City, Town or Silver S				10d. Inside City Limits 1 ☐ Yes 2 No
	with the 3a or 28a-	I Director	Oe. Street and Number 3160 Gracefield Road		10f. Zip Code 20904	10	og. Citizen of What Co USA	untry?
36	hin 72 hours after death with the Maryland B. Marical Examination 1998 of 28a-f show Marical Examination to motified at	by Funeral	Armed Force		3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh:	e, etc.
21215-0036	d within 72 hou plane r than "nature the Madical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-5+	16a. Dec (Gi life	cedent's Usual Occupation ve kind of work done during most of work by DO NOT use retired) eacher	king [Montgomery	County
Maryland 2	be filed ital Hygi id other event, I	To Be Co	17. Father's Name (First, Middle, Last) Joseph J. Guidrey		18. Mother's Nam	e (First, Middle, N A. Moran	Maiden Sumame)	
	and 2 sh ealth and n 27 Is m		19a. Informant's Name/Relationship (Type, Print) Kenneth Hayes, Jr./ Son	864	illing Address (Street and Number or Rull 1 Plymouth Road, A	lexandri	a, Virgini	a 22308
altimore,	permit. Pages 1 Department of H Importent: If iter any injury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from S 4 □ Donation 5 □ Other (Specify)	tate MD Vetera		h 6, 06	20c. Location - City or Cheltenham	
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licensee	er	Francis Address CF3 Yins 500 University Blv	d, W, Si	lver Sprin	g, MD 20901
100	Priysician /Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	or as a consequence of):	Weart Josen	_		Interval Between Onset and Death
68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dicai	that initiated events resulting in death) Last C. Due to (c	or as a consequence of):				
.O. Box	that the death certific led by the attending p detached for use as t	Physician/Me	230. Was decedent pregnant 1 Live bir	int at time of death	3 Ectopic pregnancy 5 Other (specify)		23d. Date of del Month	ivery Day Year
4	w requires that been signed by should be deta	by	Part II. Other significant conditions contributing to dea	ath but not resulting in the	e underlying cause given in Part I.		oacco use contribute to es 2 □ No 3 □ Pr	_
al Records,	The ate h page	Completed			20 81 (D.	24a. Was ar autops perform 1 Yes 2	y prior to death? 2 1 □ Yes	utopsy findings available completion of cause of
sion of Vital	Jing Phys J. After this funeral di	ation: To Be	27. Manner of Death Natural 5 Pending 2 Accident Investigation	npatient 2 ☐ ER/Outpat f Injury n, Day Year) 28b. Time Injur	trient 3 DOA Other: 4 Nursing H e of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe ho	once 6 □Other (Spe ow injury occurred	
Division	ospitel or Attend hours after death uneral Director: ly filled in by the	Certification:	4 Homicide determined buildin	of Injury - At home, farm, ig, etc. <i>(Specify)</i>		City or Town		
	To the Hospitel or Atwithin 24 hours after d To the Funeral Direct	Aedicai	(Check only one) Medical Examiner: On the ba	sis of examination and/or	eath occurred at the time, date and place r investigation, in my opinion, death occu	rred at the time, da	ause(s) and manner as ate and place, and due	e to the cause(s)
	5 Wild	×	29b. Signature and title of certifier Alley Methods	0	10043375	;	2/28/06)
	ν				FIELD ROAD SI	LVEKS	PRING, M	0 20904
	St Regist	ate rar	31. Date filed (Month, Day, Year) MAR 0 3 2006	egistrar's Signature	grade			

			For Stata Registrar		State	of Maryla		artmen rtificat			ınd M	-	giene Reg. No.	005	0.81	24.2
	A 15 A		Decedent's Name	(First, Middle,	Last)							2. Date of De	ath	ب بایا		e of Death
	Physici	- 0	Ida E. H	Hammerlun	đ							Month February	27,	2006 Year	4:25	рм
	/Medic Examin		4a. Facility Name (If	not institution,	give street and I	number)		4b. City,	Town, or	Location o				County of De	ath	
4	LAGITIII	C	St. Mary's	Nursina	Center			Lec	nardt	own			S	t. Mary'	's	
	Funeral		5. Social Security Nu		6. Sex		. last birthday)	1.	r 1 Year	If Under 2	24 Hrs. Min.	8. Date of Birt (Month, Da	th	9. B	inthplace (Sta	te or Foreign
4	Director		577-03-4714	e	1 □ M 2 🖺 F		89 Yrs.	MOULTS	Days	Hours		Oct. 22,			ennsylva	nia
	pu ,		Usual Residence of			100.0	ity, Town or Lo	nation							10d Incid	e City Limits
	aryla ehov	_	10a. State	10b. County												res 21 No
	8a-f	Director	Maryland	Montgo	mery	5.	ilver Spr		. 0. 1.				10= Cit	non of Mines C		
	hours after death with the Maryland tural; or Itame 23e or 28e-f ehow at Exec. Let must be notified at	늅	10e. Street and Num 10117 Big F						0 Code 901				USA	zen of What C	Journay :	
	e 23	Funerai		UCK NOGU		ecedent Ever in	118 13			enanic Oric	nin? (Sne	oity Yes or No		14. Race - Arr	nencan India	<u> </u>
	itam itam	n.	 Marital Status Never Marrie 	ed 2□ Marriu	Armed	Forces?	0.3.	If Yes, spe	city Cuba	n, Mexican	, Puerto	cify Yes or No Rican, etc.)		Black, Wh		''
36	ir, or	by F	3 XWidowed	_	If Yes,	Give r Dates:		1 🗆 Yes	2 🕱 No	Specify:				Specify: Whi	te	
ŏ	2 hou	ted		15. Decedent's			16a. Dece	dent's Usu	al Occupa	ation			16b. Ki	nd of Busines	s/Industry	
215	within 72 ene. then "nat	pie	(Speci Elementary/Secon		grade complete	e (1-4or 5+)	life.	DO NOT u	ise retired	luring most)	or workii	ng				
212	d with giene.	Completed	12				Se	cretar	ry				Uni	versity	of Mary	land
5	be filed within 72 hours after death with the Marylan it all typiene. All typiene. All typiene than "natural; or iteme 23a or 28a-f show event, I'm Medical Exaction merities to retified at	BeC	17. Father's Name (First, Middle, L	.ast)					18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)		
/lai	uld b Ments urkad itic e	10 [George He	nry Evel	er					Emma	E. Z	inn				
Maryland 21215-0036	2 should be fit and Mental H is marked off aumatic ever		19a. Informant's Na	.me/Relationsh	ip (Type, Print)		19b. Maili	ng Address	s (Street a	and Numbe	r or Rura	l Route Numbe	er, City o	r Town, State,	, Zip Code)	
Σ.	and ealth n 27	1	Don O. Han		Son					rlotte		, Maryla				
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked eny injury or other traumatic enge.		20a. Method of Disp		3 □Removal fro	i	Place of Dispo cemetery, cre			θ)	March	ate 3.	20c. La	cation - City o	or Town, State	9
Ë	Page ment		4 Donation				ock Creek	Cemet	tery	į	200	6 ′	Wash	ington,	DC	
Sall	Depart Import Import In In In In In In In In In In In In In I		21. Signature of Fu	neral Service L	icensee	11	Fr	2. Name a Cancis	nd Addres	s of Facility	y Funer	al Home	Inc			
	40 E E 9		1 2/1	ill	1 10%	X				-		Silver S		, MD 209	7	
				rt failure. List o	complications that only one cause o	n each line.	ath. Do not en	ter II a mo	of dyin	g, such as	ordiac o	or respiratory a	rrest,			mate Between ind Death
	Pnysician		Immediate Cause (a		ESDU	2an	ery	110	ret	Wie	2		si.	
	/Medical Examiner		resulting in death))	Due	to (or as	equency of):	a // -	1	/	TT	1	land	11		
		ایا	Sequentially list cor	nditions,	b. True	to (or as a conse	quence of):	100	ax	اح	11	MIN	IUV	-001		
	led sit	Examiner	cause. Enter Under Cause (Disease or	rlying	000	10 (01 03 001130	quanta or,									
	and al-trar	xan	that initiated events resulting in death) L		c. Due	to (or as a conse	quence of):									
8760,	The law requires that the death certificate be executed ste has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	ai														
687	ficate physics the	edicai			d											
Вох	eath certific attending p for use as	Ž.	IF FEMALE: 23b. Was decedent	nragnant		outcome of preg								23d. Date of d	lelivery	
ă	atte	ciai	in the past 12 1 Tes 2	months?		e birth 2□Fe egnant at time of		⊒Ectopic p ⊒ Other (s;						Month	Day	Year
o.	at the de by the a tached	Physician/M	9 Unknown		9□Un	iknown										
۵.	that ned b	by Pł	Part II. Other signifi	icant condition	ns contributing to	o death but not re	sulting in the u	inderlying (cause give	en in Part I.		23e. Did t	obacco u	ise contribute	to the cause	of death?
Records,	quires n sign uld be											1 🗆 '	Yes 2	2No 3□1	Probably 4	□Unknown
00	aw require	jet										24a. Was		24b. Were	autopsy lindir	ngs available
Re	The la	Completed											rmed?	death?	o completion ? es 2 No	of cause of
Vital		a a	25. Was case refer	red to medical						26. Place	of Death	1 Yes			35 2 140	
>	Physician: this certific ral director,	0 8	examiner? 1 ☐ Yes 2.5	No	Hospital: 1	☐ Inpatient 2 (☐ ER/Outpatie	nt 3□ D	OA Oth	25		me 5 ☐ Resi		6 □Other (Sp	pecify)	li li
of		n: T	27. Manner of Death		28a. Da	ite of Injury fonth, Day Year)	28b. Time o	of	28c. Injun			28d. Describe				
Ö	nding lath. r: After e funer	atio	1 Matural 2 ☐ Accident	5 Pending investig	,	onin, Day 1 ear)	Injury	М		Yes 2 ☐ f	No					
Division	or Attending after death. Director: Afte in by the fune	ific	3 ☐ Suicide 4 ☐ Homicide	6 □ Could n determi	ned 288. Pl	ace of Injury - At illding, etc. (Spec	home, farm, st	reet, factor	ry, office			28f. Location (City or To			Rural Route I	Vumber,
Ö	s after d si Direct ed in by	Certification:				maing, etc. (oper						0.1, 0.1.0	, oraco	,		
	To the Hospitel of within 24 hours all to the Funeral D completely filled in		29a. Certifier (Check only	1 Certifying	Physician: To	the best of my ki	nowledge, deal	th occurred	at the tin	ne, date an	d place,	and due to the	cause(s)	and manner	as stated.	sa(s)
	the H the F the F	Medicai	one)	//		anner stated.						ou at the time,				
	To To	2	29b. Signature and	Me of certifier	1		AAA	29	c. License	number	110	7	29d. Dat	te signed (Mo	nth, Day, Yea	ar)
•	4		•	ame	XI. X	NO	TVV	1/	DO	200	t//		d	-00	1-0E	2
			30. Name and add	ess of person v Jarboe, M	vho completed c I.D. 240	ause of death (Ite 35 Three I	em 23a) (Type Notch Ros	Print) ad, Hol	llywoo	d, MD	20636					
l.,	No. 1		31. Date filed (Mon		1/											
-	Sta Registi		ST. Date med (MDI)	MAR O	3 2008 3	2. Pagistrar's Sign	K A	Bert.	9							

			For State Registrar	State of Marylan		artment of H rtificate of			iene	08243
197			Decedent's Name (First, Middle, Last))				2. Date of Dea	th	3. Time of Death
	Physici /Medi		Audrey	M. Hall				Feb.	27, 2006	
	Examir		4a. Facility Name (If not institution, give				r Location of Death		4c. County of Dea	
		200 A	Suburban Hospit			Bethe			Montgo	
	Funeral Director		3/1-00-1902	7. Age (In yrs.)	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 1ay 22,		rthplace (State or Foreign Country) yland
	and		Usual Residence of Decedent 10a. State 10b. County Pri	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Maryl -f •hc	į	faryland Georg	nce e's		Forestv	ille			1 ☐ Yes 2 🛣 No
	or 28a	Directo	10e. Street and Number			10f. Zip Code	. –	1	0g. Citizen of What C	country?
	23a c		6603 Hilmar Dri	ve		207	47		USA	
920	72 hours after death with the Maryland natural, or Itema 23a or 28a-f ehow disel Examinat must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2X No	lispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: B1	ite, etc.
2-0	hin 72 hor a. an "natur	ted	15. Decedent's Edu (Specify only highest grade	cation	16a. Deced	dent's Usual Occup	ation during most of work	ina	16b. Kind of Busines	s/Industry
21215-0036	within 7 ene. than "c	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)	ing .	Someone	Else's
	filed w Hygiel other ti		1 2 17. Father's Name (First, Middle, Last)			Domesti	C 18. Mother's Name	a (First Middle	Home	
Maryland	e da la b	To Be	Edward	Wi	11s		Lola	В.	Emerso	n .
ary	s 1 and 2 should f Health and Mer item 27 ie marke other traumatic	1-	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ng Address (Street	and Number or Rura	al Route Number	, City or Town, State,	Zip Code)
	1 and 2 Health a tem 27 is		Myron Spriggs/S		.1		Oaks Bl	vd. #31	.05 Bowi	e, MD 2071
Baltimore,	permit. Pages 1 are Department of Heal Important; if Item any injury or other page.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Man Man Man	ses C	sition (Name of natory or other place emetery	3/4/	/2006	20c. Location - City o Lothian,	MD
Balt	permit. Departi import any inj gnce.		21. Signature of Funeral Service License	Servell	1	Name and Address 451 Dar	es Beach	well Fu n Rd. F	neral Ho rince Fr	ome ed.,MD20678
8	Physician /Medical Examiner	16	23a. Pant1. Enter the d/sease, or compl shock, or heart failure. List only or fmmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	ications that caused the death ne cause on each line. Due to (or as a consequence). Due to (or as a consequence).	efic uence of):	er the mode of dyir		or respiratory arr	est,	Approximate finterval Between Onset and Death Sycasus
,0	cate be executed physician and the burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c				-		
8760,	cate b physic the bi	dical		J					-	
.O. Box 6	The law requires that the death certificate has been signed by the attending to agge 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 more s? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	Ideath 3	Ectopic pregnancy Other (specify)	,		23d. Date of do Month	alivery Day Year
Δ.	uires that n signed b ild be deta	ρ	Part II. Other significant conditions cor		ulting in the u	nderlying cause giv	en in Part I.	23e. Did to		to the cause of death? Probably 4 □Unknown
Records,	The taw requiri ate has been si page 2 should I	Completed						24a. Was a autops perform	ned? prior to death?	autopsy findings available completion of cause of
ital	ician: T certificat rector, pa	Bec	25. Was case referred to medical examiner?				26. Place of Death			
of (Physicia this cer ral direct	ပ္	1 □ Yes 2 □ M6		ER/Outpatien		4 Nursing Ho		ence 6 □Other (Sp	ecity)
	ding P h. After i funera	tlon	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of fnjury	Wor	y at k? Yes 2 □ No	28d. Describe ho	ow infury occurred	
Division	ten for: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify				28f. Location (Si City or Town	reet and Number or F n, State)	Rural Route Number,
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: At completely filled in by the fur	edical Ce	29a. Certifier (Check only one) Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or in	n occurred at the tir vestigation, in my o	ne, date and place, pinion, death occurr	and due to the cred at the time, d	ause(s) and manner a ate and place, and du	as stated. le to the cause(s)
	To the within 2 To the complex	Me	29b. Signature and title of certifier	1		29c. Licens	e number	2	9d. Date signed (Mor	nth, Day, Year)
)			Une	namb		73	3224.	F	EBRUARY	27,2006
	5		30. Name and address of person who co	ompleted cause of death (fterm	23a) (Type,	flen Rd-	#435, Du	lver s	ate and place, and du 9d. Date signed (Mor EBRUARY	020910
	Sta Registi		31. Date filed (Month, Day, Year) MAR -	2 2006 Signa	ture	pole	,		0	

DHMH 17 Rev 1/2001

Registrar

Status.

			1 - For State of Maryland / Department	artment of Health and N		ene 006	08245
	Dhoolai		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		WALTER L. HILL		MARCH	1, 2006	2240 M
•	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Peninsula Regional medical Center	Salisbury		Wicomic	0
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 206–26–7091 1 № M 2 □ F 73 Yrs.	If Under 1 Year Tf Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth Cou	place (State or Foreign ntry)
	Director		Usual Residence of Decedent		6-9-193	Z PENI	NSYLVANIA
	yland		10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits
	Mar a-1	ctor	DELAWARE SUSSEX MILLVII	LLE			1 Yes 2 □ No
	or 28	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	ntry?
	deeth with the Maryland me 23a or 28a-f ehow finast be notified at	ral	765 HICKMAN DRIVE	19967		US	
	item item	Funeral	Armed Forces?	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
0000	rs aft	by F	1 Never Married 2 M Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: WHI	rF
5	within 72 hours after ene. then "neturel", or ite to Medical Examina		15. Decedent's Education 16a. Deced	dent's Usual Occupation	1	6b. Kind of Business/Ir	
2	nin 7.	ple	(Specify only highest grade completed) (Give life. I	kind of work done during most of work DO NOT use retired)	ino a	TEEL MANUF	•
7	giene grene er the	Completed		PPING CLERK			
	be filed within 72 hours after deeth with the Marylan Hygiene. do ther then "neture!, or iteme 23a or 28a-f ehow event, it a Medical Examinar must be notified at	Be (17. Father's Name (First, Middle, Last)		e (First, Middle, M	aiden Sumame)	
<u>x</u>	should be nd Menta marked umatic ev	ပ	EDWARD HILL	ANNI	E STILE		
Jar	2 9 2 2			ng Address (Street and Number or Run	- 20		- ,
ອົ ອົ	is 1 and of Health Item 27 other tr		MARJORIE G. HILL/ WIFE POST 20a. Method of Disposition 20b. Place of Dispo	OFFICE BOX 53, MI			
2	Peges ment of I ant: if it ury or o		1 ☐ Burial 2 Ki Cremation 3 ☐ Removal from State CATE HEN	LOPEN place)	· · ·	Oc. Location - City or T	
апти	ontment contant: injury c		4 □ Donation 5 □ Othe) (Specify) CREMATOR 21. Signature of Fun, at Service Location.			RANKFORD,	DELAWARE
o O	permit. Departr Imports any inju			en so nd funerai dheerv Est avenue, ocean	_		970
			23a. Part1. Enter the disease/or complications that caused the death. Do not ent-				Approximate
	hysician		Immediate Cause (Final	Of in	,		Interval Between Opset and Death
	/Medical		disease or condition resulting in death) Due to (or as a consequence of):	c shack			Bours
	Examiner		Xe chanda	CANDLANGE	Ahr		3 bays
	. =	Der	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	and the state of	21.19		- 1
	ocute ind trans	Examiner	that initiated events c. Acute Mya	cardial Int	Farcto	n	3 Days
Š	sate be executed physiclen and the burial-transit		resulting in death) Last Due to (or as a consequence of):	A II A			W.
00/0	requires the the death certilicate be executed een signed by the ettending physicien and hould be deteched for use es the burial-transit	dlcal	d Coronary	Jantury Di	souse		jenry
×	w requires thei the death certific been signed by the ettending p should be deteched for use es	Completed by Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy				
	etten etten for u	cian	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year
j į	the d y the sched	ysl	1 Tyes 2 No 4 Pregnant at time of death 5 C 9 Unknown	JOHNER (Specify)			
Γ.	s thet ned b s dete	y P	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did toba	acco use contribute to t	he cause of death?
SDIO	quire en sig uld bu	ed b	Hypertension; COTD		1 🗌 Yes	s 2□No 3□Pro	pably 4 Unknown
	_ D G	plet	Dystinidamia		24a. Wasan		ppsy findings available
č	The law ate has b page 2 si	E	7777		autopsy perform 1 Yes 2	ed? death?	mpletion of cause of 2□ No
9	rtifica ctor. p	Bec	25. Was case referred to medical	26. Place of Deat	h (Check only one	7	2010
> 5	nysio his ce I dire	2	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	t 3 DOA Other: 4 Nursing Ho	me 5 Resider	nce 6 Other (Speci	(y)
	ing P		27. Manner of Death 1 ☐ Hatural 5 ☐ Pending 28a. Date of Injury 28b. Time of (Month, Day Year) Injury	28c. Injury at Work?	28d. Describe how	v injury occurred	
2	tend leath. tor: A the fu	cat	2 Accident investigation	M 1 Yes 2 No			
NV15	or At ifter of Direct in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,
_	I on the hospitel or Attending Physicien: The law within 24 hours eiter death within 24 hours eiter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.		29a. Certifier 1 Certifying Physician: To the heat of my knowledge days	Companied at the state of the Companies	and the fact	LOVEN LONG TO SERVICE STATE OF THE SERVICE STATE OF	ENCO.
:	24 h	edical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or invane) and manner stated.	vestigation, in my opinion, death occur	red at the time, da	te and place, and due t	the cause(s)
	To the	Me	29b. Signatury and title of certifier	29c. License number	29	d. Date signed (Month,	Day, Year)
			Y have the distance of the	1)5592	7 /	Janet Z	nel 2006
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) /6/L	Milteral 81	I wan y	7.00
. /	0		Chartin D. Sound MD 110 De	Imagrathent Su	te 405	Salisha	MD 71804
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1		7	
	Registr	ar	MAR 0 6 2005	DOME!			

		-	For State Registrar	State of N	/larylan		rtment tificate				giene Reg. Nb.	6	0821	6
			Decedent's Name (First, Middle, Landson L	ast)						2. Date of Dea	ath Day	Year	3. Time of D	Death
	Physicia		Dorothy Ann	Hagood						Month 03		006	3:40	РМ
	/Medic Examin		4a. Facility Name (If not institution, gi		er)		4b. City, To	own, or Lo	cation of Death		4c. County	of Death		
н			Long View Nur	sing Hor	ne		Mano				Carr			
	Funeral			Sex 7.7 1 M 2 F		last birthday) Yrs.	If Under 1 Months		Under 24 Hrs. Hours Min.	8. Date of Birt Month, Da 01/30	h y, Year)	Cour		Foreign
	Director		225-14-2939 Usual Residence of Decedent		83	115.				01/30	/1923	Vir	ginia	
	and and		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1	0d. Inside City	/ Limits
	Mary 1 sh	to	PA York		Ha	nover							1 Tes	2∰No
	r 28a	rec	10e. Street and Number				10f. Zip C	ode			10g. Citizen of	What Cou	ntry?	
	h with	a D	145 Ridgewood	Drive			17	331			USA			
	ems a	Funeral Director	11. Marital Status	12. Was Decede Armed Force		.S. 13. V	Vas Decede Yes, specif	nt of Hispa y Cuban, I	anic Origin? (Sp Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Rad Bla	ce - Americk, White,		
9	or th		1 Never Married 2 Married	If Yes, Give	•	.	☐ Yes 2	⊉No S	Specify:		Specif	v: Wh	ite	
21215-0036	hours tural	ed by	3 ∰Widowed 4 ☐ Divorced	Year or Date	5:	16a Decer	lent's Usuai	Occupation	on.		16b. Kind of B	usiness/ln	dustry	
<u>.</u>	in 72	Completed	(Specify only highest g	rade completed)	-5.	(Give		done duri	ing most of work	ing			ĺ	
7	iene.	mo	Elementary/Secondary (0-12)	College (1-4d	or 5+}	Assis	stant	Bra	anch Ma	nager	Bank	ing		
פַ	e filec II Hyg otha vent,	Bec	17. Father's Name (First, Middle, Las	st)				18	B. Mother's Nam					
<u>/la</u>	should be filed within 72 hours after death with the Maryland ind Mental Hygiene. Ind Mental Hygiene s marked other than "natural", or items 23a or 28a-f show a marked other than "natural", or items 23a or 28a-f show umatic event, the Madrell Examiner must be notified at	To	Gilbert Frank	lin Long	J						chwart:			
Maryland	2 shoand and Is m		19a. Informant's Name/Relationship						NumberorRur d Drive					
	and lealth m 27 her tr		Sharon Hofman	n -Daugh		140				Date	20c. Location			
lore	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 1			cemetery, crer	natory or oth	ier place)			Laure	1		
Baltimore,	tt. Pa rtmen rtant: njury		' 4 □ Donation 5 □ Other (Spec		ER		. Name and	-	em 03/0			_		
Bal	permit. Departr Importa any inju		Steven W.	Eline	M007	23	934 5	outh	n Main	Stree		Home stea	d MD	21074
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that causely one cause on each	sed the dea h line.	th. Do not ent	er the mode	of dying,	such as cardiac	1	4 4		Approximate Interval Betwood	veen
	Physician		Immediate Cause (Final disease or condition	- chre	mic	obs	sten	18th	re 1	>N IDI	Lina	alla	- Com	
	/Medical Examiner		resulting in death)	Due to (or	as a consec	quence of):					'			
		7	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consec	quence of):								
	petr	Examiner	cause. Enter Underlying Cause (Disease or injury											
C.	exection and training the same same same same same same same sam	Еха	that initiated events resulting in death) Last	Due to (or	as a conse	quence of):								
8760,	cate be executed bhysician and the burial-transit	Physician/Medical		d								-		8-1
9	ndiffica ng ph	Med	IF FEMALE:											
Вох	w requires that the death certific been signed by the attending p should be detached for use as:	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	n 2 ☐ Fet	al death 3	Ectopic pre					ate of deliv onth	*	'ear
Ö	the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□ Pregnan 9□ Unknow		geath 5	Other (spe	спу)						
P.O.	that the od by detact	/ Ph	Part II. Other significant conditions	s contributing to deat	h but not re	sulting in the u	nderlying ca	use given	in Part I.	23e. Did	obacco use cor	tribute to	he cause of de	eath?
ds,	uires sign ld be	Completed by	Deplinio.	Λ,	aste	2000	Sus	2		1 🗆	Yes 2□No	3 ☐ Pro	bably 4 😾	Inknown
COL		lete	· ·	•		,				24a. Was		Were aut	opsy findings a	available
Re	: The taw r cate has be page 2 sh	Juo								auto perfe	ormed? 2 X No	death?	mpletion of ca 2XNo	iuse oi
ital		a)	25. Was case referred to medical					2	26. Place of Dea					
_ <	ys	ToB	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inp	atient 2	ER/Outpatier	nt 3 DO	A Other:	4 Nursing H	ome 5 Res	dence 6 Ot	her (Speci	fy)	
0 0	ng Ph fter th ineral		27. Manner of Death 16 Autural 5 Pending	28a. Date of (Month,	Injury <i>Day</i> Yea <i>r)</i>	28b. Time o Injury		3c. Injury a Work?		28d. Describe	how injury occu	rred		
sio	Attending r death. ector: Afte by the fune	catl	2 Accident investigat 3 Suicide 6 Could not	1 50			M		es 2 No	28f Location	Street and Num	her or Ru	al Route Numi	her
Division of Vital Records,	lor At after of Direct In by	ertification;	4 Homicide determine		, etc. (Spec	nome, farm, st ify)	eet, lactory,	onice			wn, State)			
-	spital	0	29a. Certifier Certifying	Physician: To the be	est of my kn	owledge, deat	h occurred a	it the time	, date and place	, and due to the	cause(s) and n	anner as	stated.	
	To the Hospital or Attending is within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical Ex	caminer: On the bas and manne		ation and/or in				rred at the time,)
		Ž	29b. Signature and title of certifier	~~ <i>(</i>	M			License r	number	5	29d. Date sign	ed (Month	Day, Year)	
7	WIL		, 6, 10					، ر	51705		2-		6	
_	4		30. Name and address of person when the survival of the surviv	A 349	wa	Molec		2	Kestr	ninstes	5 W	in:	2115	7
	Sta Regist		31. Date filed (Month, Day, Year) MAR 0	3 2006 D	gistar's Sign		Corne	,						
		9				-	10 To 10 To							

			1 - For Amend Items State Registrar 1. Decedent's Name (First, Middle, La		aryland / Der f per ME (partment of I 3856, 0672 Prifficate of	lealth and 9 /06dh b <i>Death</i>	Mental Hy		0 8 2 4 7
	Physic /Medi Examir	cal	M2/N2+d 4a. Facility Name (If not institution, give	D the	Laxe	4b. City, Town, o	or Location of Dea	Month 03	Day Year 200 L	4:15 PM
1	Funeral Director			Sex 7. Ag	92 Yrs.	Months Days	If Under 24 Hr Hours Mir	1. (Month, Da	th 9. Birth	nplace (State or Foreign
	a-f show	ctor	10a. State 10b. County Maryland Wicomic	0	10c. City, Town or L Salisbury		-			10d. Inside City Limits 1 ☐ Yes 2 No
3	within 72 flours after beath with the Maryland ane. Tha Medical Exaction frant be rediffed at	by Funeral Director	10e. Street and Number 1110 Healthway D 11. Marital Status 1 Never Married 2 Married 3 M Widowed 4 Divorced	rive 12. Was Decedent Amed Forces? 1 □ Yes 2 ☑ If Yes, Give Year or Dates:	Ever in U.S. 13	10f. Zip Code 21801 Was Decedent of Hif Yes, specify Cub 1 Yes 2X No		Specify Yes or No into Rican, etc.)	Specify:	ican Indian,
	trail Hygiene. Id other than "natural", event, the Medical Est	Completed by	15. Decedent's E (Specify only highest gri Elementary/Secondary (0-12)		(Giv life.	edent's Usual Occup e kind of work done DO NOT use retire	during most of w d)	orking	16b. Kind of Business/I	ndustry
	marke marke	To Be C	17. Father's Name (First, Middle, Last George Hugo 19a. Informant's Name/Relationship (19b. Ma i	ling Address (Street	Rena M:	iller	Maiden Sumame) er, City or Town, State, Z	in Code)
` ,	of Health a		Ronald Hugo 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special	☐Removal from State	22804 20b. Place of Disp	4 Lee Moning of Manager of County	t Road,	P.O. Box	168, Parks1 20c. Location - City or 1 Towanda, Pen	ey, VA 2342 Town, State
	Department of the partment of		21. Signature of Funeral Service Lice	was CF	-SP 5	2. Name and Addre IOLLOWAY F IOL Snow H	uneral I Iill Rd.	Home P.A. Salisbur	y, Maryland	
	hysician and provided and provided and the price of the p	dical Examiner	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Sub Due to (or as b. Due to (or as c.	a consequence of): a consequence of):	Hemi	toms	FICA ON APPROVE	A Junier	Approximate Interval Between Onset and Death a
10000	by the attending parached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnancy	ý		23d. Date of deliving Month	very Day Year
and the state of	been signed by should be detac	by	Part II. Other significant conditions (contributing to death b	ut not resulting in the	underlying cause giv	ven in Part I.	23e. Did to	obacco use contribute to	
The fam.	ate has b	e Completed	25. Was case referred to medical					24a. Was autop perfor 1 \(\subseteq Yes	prior to continue	opsy findings available ompletion of cause of
And the second s	h. After this funeral dii	ertification: To Be	examiner? 1 X Yes 2 No. 27. Manner of eath Natural 5 Pending investigatio		ry 28b. Time	of 28c. Injur	er: 4 🗆 Nursing	28d. Describe h	me) dence 6 □Other(<i>Spec</i> nowinjury occurred quent fall s	
	ours afte	O	3 Suicide 6 Could not be determined	Assiste	d Living f	acility	me, date and plac	Atria Li	Street and Number or Rui Ving Facili way Di cause(s) and manner as	ty, 1110 isbury, MD
To she Us	within 24 h To the Fur Completely	Medical	(Chack only one) 2 Medical Example 29b Signature and title of certifier	and manner sta	examination and/or it	29c. Licens	pinion, death occ	curred at the time, o	date and place, and due 29d. Date signed (Month)	to the cause(s) Day, Year)
	Da		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type	, Print)	6x17	33 1	alu L Mil	21802
	Sta Registr	- 3 4	31. Date filed (Month, Day, Year) MAR 0 3 2	32. Registra	ar's Signature	land.			0	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Hastings Dryden Joanne February 28 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Keninsula Regional medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 8/5/1941 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Days 1 M 2 KF 216-40-3567 Deláware 64 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 1 and 2 should be filed within 72 hours after death with the Maryiar if Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f ehow other traumatic event, the Medical Exam. at most be notified at 1 ☐ Yes 2 No Salisbury Wicomico Maryland Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21801 28509 Old Ouantico Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2**K** No If Yes, Give Year or Dates: 1 Never Married 2 Marned white 1 ☐ Yes 2 No Specify: Specify: ģ 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) State Government 11 Dietician 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Gladys Crowley Woodrow Dryden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26402 Big Mill Rd., Georgetown, DE 19947 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 a Department of Health ar Important: if Item 27 is any injury or other trau s00.0. Woodrow R. Dryden/brother 20b. Place of Disposition (Name of comptay, crematory or other place)
Franklin City
Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Greenbackville, VA 3/4/06 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligensee THOTTOWAY TUNETAL Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 +J& 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary artery disease years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 Mellitus 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Obstructive pulmonary disease performed? 1 ☐ Yes 2 No of Vital 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: After Division 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dav. Year) 29c. License number 29b. Signature and title of contifier D58689 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E. Carroll St. Salisbury, m.D. 21801 Swierkosz 10masz 32. Pegistrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 3 2006 Registrar

			For State Registrar		State of	Maryland /	-	artment rtificate					Reg. No	111	5 U	8249
	Physicia	an	1. Decedent's Name (Fin			70						2. Date of De March	ath Pa	у ,	2006	3. Time of Death
	/Medic Examin	al	William 4a. Facility Name (If not 3815 East	institution, gi	ve street and nun				Town, or ngdc	Location o				. County	of Death	1 00
	Funeral Director		5. Social Security Numb 212-26-88	er 6. 78		7. Age (In yrs. last 75	birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	B. Date of Bir (Month, Da ay 2,	th Year))	9. Birthpla Count Mary	ace (State or Foreigr y) Land
	and w	}	Usual Residence of Dec 10a. State 10b	edent o. County		10c. City, T	own or Lo	cation							10	d. Inside City Limits
	Mary I sho	tor	MD	Harfo.	rd	I	Havre	de G	race	2						ty∑Yes 2 □ No
	with the	Direc	10e. Street and Number		ronio A	pt.#308		10f. Zip					10g. Cit		What Count	ry?
99	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel; or Items 23a or 28a-f show any injury or other treumatic event, the Medical Exertirer rust be institled at once.	Completed by Funeral Director	505 Congri	2□ Married	12. Was Dece	dent Ever in U.S.			ient of Hi orfy Cuba	spanic Orig n, Mexican Specify:	n, Puerto A	city Yes or No lican, etc.))-		ce - America ck, White, e	tc.
9	hours turel',	ed b	3 ☑ Widowed 4 ☐	Divorced, Decedent's E			6a. Dece	dent's Usua	al Occupa	ation			16b. K	and of B	usiness/Indi	
21215-0036	s within 72 piene. r than "ne	ompiet	(Specify of Elementary/Secondary 12	nly highest g	rade completed) College (1		(Give life.	kind of wor DO NDT us Self	rk done d se retired	lu <i>ring m</i> osi)		g	Who]		le & F	Retail
Maryland 2	2 should be filed withir and Mental Hygiene. is marked other than eumatic event, the Men	To Be C	17. Father's Name (First William									(First, Middle Addisor		Surnan	пө)	
Mary	and 2 should saith and Men n 27 is marke ier treumatic		19a. Informant's Name/ Bonnie D					ng Address Easto				Route Numb Jdon, N		or Town, 2100	_	Code)
Baltimore,	Pages 1 and 3 nent of Health of Health sut: If item 27 ury or other tr		20a. Method of Disposit 1X Burial 2 Cr 4 Donation 5	emation 3		cem	etery, cre-	osition (Name matory or o	ther plac	e) 3 st Ce	/15/C	16			City or Tow	vn, State
Balti	permit. Page Department of Importent: If any injury of ang.		21. Signature of Funera	I Service Lice	ensee 30	0-11		Name an Parrir Aberd		s of Facilit	Funer 21001	al Hom -3399	ne,]	P.A.		
			23a. Part1. Enter the di shock, or heart fai	isease, or con	mplications that c	aused the death. I							rrest,			Approximate Interval Between Onset and Death
1760, <	/Medical Examiner /Medical Examiner the parial-transit	icai Examiner	Immediate Cause (Fina disease or condition resulting in death) Source trially flat condition flat, leading to immediate, leading to immediate, leading to immediate cause. Enter Underlyin Cause (Disease or injurthat initiated events resulting in death) Last	(с.	or as a consequen		E d	lise	eas	y) kt	o hy	M)	ngle		7 hell
.O. Box 68	death certific e attending p id for use as i	by Physician/Med	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ths?	1 Live b	come of pregnancy irth 2 Fetal de ant at time of deat own	ath 3[□Ectopic pr □ Other (sp					10		ite of deliver	y Day Year
٩	requires that the een signed by th nould be detache		Part II. Other significan	t conditions	contributing to de	eath but not resulting	ng in the u	enderlying c	ause give	en in Part I	l.		tobacco Yes 2		tribute to the	cause of death?
Records,	e taw has b	Completed											psy ormed?		prior to com death?	sy findings available pletion of cause of
Vital	ilcien: Th certificate rector, pag	e l	25. Was case referred	o medical						26. Place	e of Death	1 ☐ Yes (Check only	2 No	2	1 ☐ Yes	2 X No
of Vi	ding Physicien: h. After this certific funeral director,	To B	examiner?				VOutpatie			4 140		ne 5□Res			iei (Specily)	aughters Residence
o uc	79 00 0	lon:	/	Pending		of Injury 28 th, Day Year)	Bb. Time o	of 2	8c. Injury Worl	≀at <br Yes 2 □		8d. Describe	how inju	iry occur	red	
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	Accident Control Contr	investigati	be 28e. Place	of Injury - At home ng, etc. (Specify)	e, farm, st			163 2	_	8f. Location (City or To			ber or Rural	Route Number,
_	Hospitel 24 hours Funerel etely filled	edical C			aminer: On the b	best of my knowle asis of examination ner stated.										
)	To th within To th	Me	29b. Signature and title	of certifier	Od (M		290	C. Licenso	number	44	8	29d. Da	ate signe	ed (Month, E	Pay, Year)
	441		30. Name and address	of person wh	o completed caus	e of death (Item 2	3a) (Type	Print)) 7	MIN	1/10	A A	10	HA	CE	12107
	Sta	te	31. Date filed (Month, L		32. F	egistrar's Signatur	0	701)		VU 1	unc	NV		1,1	0	y 7 / 6
Di	Regist	ar	MA	R16	2006	alexan A	1									
U	.vii 17 mev 1/2	JUI				O	RIGIN	AL								

			1 - For State Registra AMEND#5perFH3/6/	State of Maryland			nt of He te of E		ind Me		ene g. No.	06	08250
			Decedent's Name (First, Middle, Last)						2	2. Date of Deat		Vasa	3. Time of Death
П	Physicia		Sigmund Ja	mes Jacob	S				F	Month Pebruary	Day 7 25.	Year 2006	6:40P M
	/Medic Examin		4a. Facility Name (If not institution, give st	treet and number)		4b. City	, Town, or	Location of				ounty of Death	
	LXaiiiii	-	Sunrise Assisted	Living		S	ilver	Spri	ng		Mor	ntgomer	Cy.
	Funeral		3.195cial Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Unde	er 1 Year	If Under 2		B. Date of Birth (Month, Day,		9. Birth	nplace (State or Foreign untry)
	Director		245 -44-3549 1 X	M 2□F 93	Yrs.	Months	Days	Hours		arch 25	1912		nesota
	D		Usual Residence of Decedent					- 1					
	how		10a. State 10b. County		, Town or Lo								10d. Inside City Limits
	B-f-	cto	Maryland Montgomer	y Si	llver	Spri	ng						1 X Yes 2 □ No
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Mudical Examinating the notified at	i Director	10e. Street and Number 11621 New Hampshir	e Ave			ip Code 20904					of What Cou	_{untry?} s of America
	ms 2	Funerai	11. Marital Status	2. Was Decedent Ever in U.	S. 13.	Was Dec	edent of His	spanic Orig	gin? (Spec	ify Yes or No-	14	Race - Amer	
0	r Ite		1 Never Married 2 Married	Armed Forces? 1 Tes 2 No		ir Yes, sp 1 □ Yes		n, Mexican,	, Риепо н	ican, etc.)		Black, White	
က္က	urs a	by	3 ĀWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ∐ Yes	2LTNo	Specify:			S	pecify: Wh	nite
Ò	2 ho	Completed	15. Decedent's Educ		16a. Dece	dent's Us	ual Occupa	tion uring most	of working	7	16b. Kind	of Business/I	Industry
215	hin 7	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	lite.	DO NOT	use retired))	Or WORKING	9			
2	d wit	Ö		5+	P	hysi	cist				Fede	eral Go	overnment
ק	oth oth	Be (17. Father's Name (First, Middle, Last)					18. Mother	r's Name ((First, Middle, M	Maiden St	ımame)	
<u> </u>	ould be filed v Mental Hygie Marked other t natic event, II	To E	Dave Jacobs					Am	elia	Labevi	tch		
a Z	s ma		19a. Informant's Name/Relationship (Typ	ee, Print)						Route Number			
Σ	alth alth 27 i		Shawn Stringer - A	Attorney	1281	8 La	cy Dr	ive,	Silve	er Spri	ng, l	MD 2090	04
e e	of He Item		20a. Method of Disposition	1 6	lace of Dispo emetery, crei	matory or	other place	9)	Da			tion - City or	
Ë	Page nr: = Z		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	Ft.	Linco	1n C	remat	ory			Bren	twood,	Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury go other traumatic events.		21. Signature of Euneral Service License	0 1	22	2. Name a	and Addres	s of Facility	Hine	s-Rinal	di F	uneral	Home, Inc.
ñ	Den Imp		12/h/	_									ng, MD 20904
			23a. Part. Enter the disease, or complic	cations that caused the death	n. Do not ent	ter the mo	de of dying	g, such as o	cardiac or	respiratory arre	est,		Approximate Interval Between
	Physician		shock, or heart failure. List only one Immediate Cause (Final										Onset and Death
	Physician /Medical		disease or condition resulting in death)	Pneumonia Due to (or as a consequence)									
	Examiner												
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):								
	sician and burial-transit	Examiner	Cause (Disease or injury that initiated events										
Ţ,	exec n and ial-tra	Exa	resulting in death) Last	Due to (or as a consequence	uence of):								
8760,	ate be executed hysician and the burial-transit	dicai	d										
89	ificate i	edi									1		
Вох	death certific attending pl	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna							23	d. Date of deli	ivery
m	death atte	cia	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		⊒Ectopic ☐ Other (:	pregnancy s <i>pecify)</i>					Month	Day Year
oj.	that the de led by the a detached f	lysi	9 Unknown	9□ Unknown									
مرّ	res that igned b be deta	Y.	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	ınderlying	cause give	en in Part I.		23e. Did tot	acco use	contribute to	the cause of death?
g	uires sigr d be	P	Dementia							1 □ Ye	s 2 🗆	No 3□Pr	obably 4 XUnknown
ö	w require been si should b	ete								24a Wasa	0	24h Were au	itonsy findings available
ğ	has ge 2	m								autops	y ned?	prior to death?	itopsy findings available completion of cause of
<u></u>	Physician: The la rthis certificate has ral director, page 2									1 ☐ Yes	2 🔕 No	1 🗌 Yes	2 No
<u> </u>	iciar certif recto	Be	25. Was case referred to medical examiner?	ospital:			Othe	0.0		(Check only on		ASSIS	sted Living
ō	Phys this al dii	5	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 Inpatient 2	ER/Outpaties 28b. Time of		JOA	4 🗀 1901		e 5 Reside			cify)
Ä	ling After funer	5	1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	M M	28c. Injury Work	k? Yes 2 □ N		ou. Dosonibo in	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	5554.100	
S	Attending Physician: The law requires that the death certific rideath. •ctor: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as by the funeral director, page 2.	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	39a Bloop of laiver. At he	ama farm at					8f Location (St	reet and	Number or Ri	ural Route Number,
Division of Vital Records,	after Olrection by	Certification;	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	y)	reet, rack	ory, ornice		-	City or Town	, State)	70111007 07 710	arar riodio rvanibor,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Phys	icien: To the best of my kno	wlodes de-	h ass:	ed at the time	a data ac-	d place a	nd due to the a	auso/s\ -	nd mages s	t stated
	Hos 24 hc Fun tely	S		ner: On the basis of examina and manner stated.									
	To the within 2 To the complet	Medical	29b. Signature and title of certifier	and married states.		2	9c. License	number		2	9d. Date	signed (Monti	h, Day, Year)
	₹ ¥ ¥ 8		Mund	a m-								-1-2006	
7	10		1	7011	00.1.5		D-32	332			J-	- T-2006)
			30. Name and address of person who co				~ #A 1	20 - 0	i] 1770~	- Shrin	T IMIT	2090	12
			Gupta S. Kamar, M. 31. Date filed (Month, Day, Year)	D. 9801 Georgistrar's Signa		-		ZU; 5.	TTAGI	- SDT TI	J, 1411	, 2030	,
3	Sta Registi			06	K 1	mode.							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Louis Johnson 2225 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner cheverly eorge's 7. Age (In yrs. last birthday) 6 corge rince If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) | Jan. 18, 1938 6. Sex 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 M 2□F 251-64-3236 68 So. Director Carolina Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel", or items 23e or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once. 10b. County Prince 10c. City, Town or Location 10d. Inside City Limits 10a. State Capitol Heights 1 ☐ Yes 🏋 ☐ No Directo Maryland George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 303 Goldleaf Ave. 20743 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Dept. of Public Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Works & Transportat 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ralph Johnson Eva ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis Johnson, Jr./son 303 Goldleaf Ave. Capitol Heights, MD20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Macedonia UMC Cem. 2/27/2006 Cottageville, SC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home Bladen G. Sewell

23a. Part 1. Enter the risease, or complications that bused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1451 Dares Beach Rd. Frince Fred., MD20678 Approximate Interval Between Onset and Death Immediate Cause (Final ArTerios devotic Hypertensore Heart Discore **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed this certificate 2□ No 1 Yes 2/ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To ÷ After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 TYes 2 TNo investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 1503 WSTE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 4 2006 Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

\mathbf{m}
P.O. Box 68760,
Records, P
of Vital
sion (

Physici	144.	Registrar 1. Decedent's Name (First, Middle, Last)	State of Marylan 23a per Dr.,	Certific	ate of Death	2. Date of Death)	3. Time of Death
/Medic		Margaret Catheri				March	b 2004	
Examir	ner	4a. Facility Name (If not institution, give s			City, Town, or Location of Deat	h	4c. County of Deat	
Euporol	11	+HE MEMORTA 5. Social Security Number 6. Sex		last birthday) If U	EAS FON nder 1 Year If Under 24 Hrs		TALB 9. Birt	thplace (State or Fore
Funeral Director			M 2 X F 92	Yrs. Mon	ths Days Hours Min.	(Month, Day, 10/13/19		ryland
Department of Health and Mental Hygiene. Important: or Items 23a or 28a-f show eny injury or other treumatic event, the Modical Exeminer must be notified at once.	Director	10a. State 10b. County MD Caroline		ty, Town or Location $1 dsboro$				10d. Inside City Lim 1 ☐ Yes 2
De n	Dire	10e. Street and Number		10f	. Zip Code	10	g. Citizen of What Co	ountry?
18 23.	era	15125 Day Road	12. Was Decedent Ever in U	S 13 Was D	21636 ecedent of Hispanic Origin? (S	Specify Yes or No-	USA 14. Race - Ame	erican Indian
if, or item Xeminer	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Yes,	specify Cuban, Mexican, Puer os 2 No Specify:	to Rican, etc.)	Black, Whit	
n "natura	Completed	15. Decedent's Educ (Specify only highest grade	completed)	16a. Decedent's (Give kind o life. DO NO	Usual Occupation f work done during most of wo T use retired)	rking 1	6b. Kind of Business	
r the	E	Elementary/Secondary (0-12)	Coflege (1-4or 5+)	homema	ker		own home	
othe	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle, M	laiden Sumame)	
Menta rrked rtic e	To E	Frederick Hartlov	/e		Margar	et Presto	n	
Ith and A 27 is ma r treuma		19a. Informant's Name/Relationship (Type Joe C. Johnson / so		3	ress (Street and Number or R			
tem tem other		20a. Method of Disposition	20b. F	Place of Disposition cemetery, crematory	(Name of	Date 2	Oc. Location - City or	Town, State
t: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	amoval from State !		remation Marc	h 8,2006	Chester.	Marvland
Departm Importal eny inju		21. Signature of Funeral Service License		22. Nam Fleeg	e and Address of Facility le and Helfent	ein Fune	al Home,	
4. C.		23a. Part1. Enter the disease, or compli	cations that caused the deal	th. Do not enter the	x 160 Greensbo mode of dying, such as cardia	o ro, MD 21 correspiratory arre	_639 st,	Approximate
»		shock, or heart failure. List only on fmmediate Cause (Finaf	e cause on each line.	P	neumonia Aspir	ation		Onset and Death
ysician Medical		disease or condition resulting in death)	Due to (or as a consec	nuence of):				vears
xaminer	8		aspin	trive	Advanced Demer	ntia		1
		a company and						aux
-	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):	0			augo
en and rial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consecuence of the consecuence of t	red	Dementi	*		year
g physicien and as the burial-transit	cal	cause. Enter Underlying Cause (Disease or infury that initiated events	adva	red	Dementic	~		year
y the attending physicien and iched for use as the burial-transit	cal	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	adva	ancy	ic pregnancy		23d. Date of de Month	year Jewy Day Year
gned by the attending phys be detached for use as the	by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	Due to (or as a consection of pregnance) 3c. If yes, outcome of pregnance of pregnance at time of constant of the pregnant at time of constant of the pregnance of the pregnanc	ancy al death 3 Ectop death 5 Othe	r (specify)	23e. Did tob	Month acco use contribute to	Day Year o the cause of death
has been signed by the attending phy: ge 2 should be detached for use as the	by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	Due to (or as a consection of pregnance) 3c. If yes, outcome of pregnance of pregnance at time of constant of the pregnant at time of constant of the pregnance of the pregnanc	ancy al death 3 Ectop death 5 Othe	r (specify)	1 ☐ Ye 24a. Was ar autops perform	Month acco use contribute to s 2 Pro 3 Pro 1 Pr	Day Year o the cause of death robably 4 Unknow utopsy findings availate completion of cause
ete has been signed by the attending phy: page 2 should be detached for use as the	Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions con	Due to (or as a consection of pregnance) 3c. If yes, outcome of pregnance of pregnance at time of constant of the pregnant at time of constant of the pregnance of the pregnanc	ancy al death 3 Ectop death 5 Othe	ng cause given in Part I.	1 ☐ Ye	Month acco use contribute to s 2 □ No 3 □ Prior to cheat? acco use contribute to s 24b. Were au prior to cheath? 1 □ Yes	Day Year o the cause of death robably 4 Unkni utopsy findings avail
ete has been signed by the attending phy: page 2 should be detached for use as the	o Be Completed by Physician/Medical	Cause Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown Part II. Other significant conditions con	Due to (or as a consection of pregnant at time of constitutions to death but not research.	ancy al death 3 Ectop death 5 Othe	ng cause given in Part I. 26. Place of De	1 Yes 24a. Was ar autops; perform 1 Yes 2	Month acco use contribute to s 2 PNo 3 Pri 24b. Were at prior to death? PNo 1 PYes	Day Year o the cause of death robably 4 □Unkn utopsy findings avail completion of cause s 2□ No
ete has been signed by the attending phy: page 2 should be detached for use as the	To Be Completed by Physician/Medical	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consection of pregnant at time of constitution of the constitution of	ancy al death 3 Ectop death 5 Othe	ng cause given in Part I. 26. Place of De	1 Yes 24a. Was ar autops; perform 1 Yes 2	Month acco use contribute to s 2 10 3 Prior to death? 1 1 Yes acco use contribute to to see the contribute t	Day Year o the cause of death robably 4 Unknow utopsy findings availation of cause s 2 No
ter death. irector: Atter this certificete has been signed by the attending physic to the funeral director, page 2 should be detached for use as the	o Be Completed by Physician/Medical	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consection of pregnant at time of constituting to death but not research of the constitution of the constituti	ancy al death 3 Ectop death 5 Othe sulting in the underlying 28b. Time of Injury Mome, farm, street, fa	26. Place of De DOA Cther: 4 \square Nursing I 28c. Injury at Work? 1 \square Yes 2 \square No	1 Ye 24a. Was ar autops; perform 1 Yes 2 ath Check only one 4ome 5 Reside 28d. Describe ho	Month acco use contribute to s 2 No 3 Pt 24b. Were au prior to death? 1 Yes 1 Other (Spew injury occurred	Day Year o the cause of death robably 4 Unknow utopsy findings availate completion of cause s 2 No
ter death. irector: Atter this certificete has been signed by the attending physic to the funeral director, page 2 should be detached for use as the	Certification; To Be Completed by Physician/Medical	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consection of pregnant at time of constitution of pregnant at time of constitution of the	ancy al death 3 Ectop death 5 Other sulting in the underlying in t	26. Place of De DOA Cther: 4 \square Nursing I 28c. Injury at Work? 1 \square Yes 2 \square No	24a. Was ar autops; perform 1 Yes 2 ath Check only one 5 Reside 28d. Describe ho 28f. Location (Str. City or Town	Month acco use contribute to s 2	Day Year o the cause of death' robably 4 Unknown utopsy findings availated completion of cause s 2 No dural Route Number, s stated.
fer death. rector: After this certificete has been signed by the attending phy. by the funeral director, page 2 should be detached for use as the	To Be Completed by Physician/Medical	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consection of pregnant at time of constitution of pregnant at time of constitution of the	ancy al death 3 Ectop death 5 Other sulting in the underlying in t	26. Place of De 26. Place of De 26. Nursing I 28c. Injury at Work? 1 Yes 2 No ctory, office	1 Ye 24a. Was are autopsy perform 1 Yes 2 ath Check only one 4ome 5 Reside 28d. Describe ho 28f. Location (Str. City or Town e, and due to the caurred at the time, da	Month acco use contribute to s 2 No 3 Pt 24b. Were au prior to death? 1 Yes 1 Other (Spewin) injury occurred eet and Number or Ristate) use(s) and manner aute and place, and due od. Date signed (Monte)	Day Year o the cause of death' robably 4 Unknot utopsy findings availate completion of cause s 2 No actify) tural Route Number, s stated, e to the cause(s) th, Day, Year)
ete has been signed by the attending phyv page 2 should be detached for use as the	edical Certification; To Be Completed by Physician/Medical	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consection of pregnant at time of constitution of pregnant at time of constitution of the	ancy al death 3 Ectop death 5 Other sulting in the underlying in t	26. Place of De 26. Place of De 27. DOA Other: 4 Nursing I 28c. Injury at Work? 1 Yes 2 No ctory, office	1 Ye 24a. Was are autopsy perform 1 Yes 2 ath Check only one 4ome 5 Reside 28d. Describe ho 28f. Location (Str. City or Town e, and due to the caurred at the time, da	Month acco use contribute to s 2	Day Year o the cause of death' robably 4 Unknot utopsy findings availate completion of cause s 2 No actify) tural Route Number, s stated, e to the cause(s) th, Day, Year)
fer death. irector: Atler this certificate has been signed by the atlending phy. by the funeral director, page 2 should be detached for use as the	edical Certification; To Be Completed by Physician/Medical	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consection of pregnance) 3c. If yes, outcome of pregnance at time of constant at time of	ancy al death 3 Ectop death 5 Othe sulting in the underlying BER/Outpatient 3 28b. Time of Injury M ome, farm, street, far fy) owledge, death occupation and/or investigation	26. Place of De 26. Place of De DOA Cther: 4 Nursing I 28c. Injury at Work? 1 Yes 2 No ctory, office rred at the time, date and place tition, in my opinion, death occ 29c. License number	1 Ye 24a. Was are autopsy perform 1 Yes 2 ath Check only one 4ome 5 Reside 28d. Describe ho 28f. Location (Str. City or Town e, and due to the caurred at the time, da	Month acco use contribute to s 2 No 3 Pt 24b. Were au prior to death? 1 Yes 1 Other (Spewin) injury occurred eet and Number or Ristate) use(s) and manner aute and place, and due od. Date signed (Monte)	Day Year o the cause of death robably 4 Unkn utopsy findings avail completion of cause s 2 No ecify) tural Route Number, s stated, e to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Pear February 28, 2006 **Physician** 5:38P M Alexandros I. Kalargyros /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery General Hospital Montgomery 01ney If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day), Hours Min. Aug. 30 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign 5. Social Security Number 6. Sex 1 → M 2 □ F **Funeral** Greece 215-82-7127 77 Aug. Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show Examiner must be notified at 1 ☐ Yes 2 ZNo Maryland Montgomery Silver Spring Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 20901 United States of America 10200 Brunett Avenue Items 23a Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturat, or the any injury or other traumatic event, I'm Medical Examina 1 X Never Married 2 ☐ Marned 1 ☐ Yes 2 X No White 1 ☐ Yes 2 ☒ No Specify: If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Business Farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Kalargyros Aspasia Sarma 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) George J. Kalargyros - Brother 10200 Brunett Avenue, Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery 03/03/2006 Silver Spring, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee any inj 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Septic Shock disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Urosepsis Sequentially list conditions, any leading to moderate cause. Enter Underlying Cause (Disease or injury Due to or as a consequence of Examine or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) the attending physician Completed by Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Day jo in the past 12 months? Month Year 5 Other (specify) ☐Yes 2☐No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 90 Progressive Dementia, Benign Prostatic Hyperplasia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖄 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? certificate 1 Yes 2 🖾 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: ٩ 1 Yes 2 No 1 Inpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2X ER/Outpatient in by the funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 5 Pendina Injury 1 X Natural 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide within 24 hours a To the Funeref I Hospital 29a. Certifier 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of pertifier

State Registrar

Baltimore, Maryland 21215-0036

Box 68760.

Division of Vital Records, P.O.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

Alan R. Segal, MD
31. Date filed (Month, Day, Year)

03

1517

D52261

Hugo Circle, Silver Spring, Md 20906

February 28, 2006

				Plea		ype or P							•		_	ole.		
			For State Registrar			State of I	Marylar		artmer <i>rtificat</i>				1ental H	ygien Reg. N	1011	5	1181	256
	A		Decedent's Nam	ne (First, Middl	e, Last)								2. Date of I	Death		Voor	3. Time	e of Death
	Physici /Medic			Marga	aret	Senio	r Lyr	ıch					Februa	ry Ž	7, 20	06	9:2	6 A ^M
	Examin		4a. Facility Name				er)				r Location	of Death			c. County of			
		<u> </u>	Prince 5. Social Security 1		s He		Ago (la ura	last birthday)		heve 1		r 24 Hrs.	Q Data of F	1	rince			
Wer	Funeral Director		216-15-6	537		M 2⊠F /.	67	Yrs.	Months		Hours	Min.	8. Date of E (Month, I July	8, 19	938	Jama	ntry)	te or Foreign
	and wo		Usual Residence of 10a. State	10b. County			10c. Ci	ty, Town or Le	ocation					_		1	10d. Inside	City Limits
	Mary -1 ehc	į	Md.	Prince	Geo	rge's	A	.delphi									D(X)	′es 2□No
	r 28a	rec	10e. Street and Nu							p Code				10g. C	itizen of W	hat Cou	intry?	
	th wit	Funeral Director	1836	Metzero	tt	Rd. #12	202			2078	33			1	U.S.A.			
	r dea	ner	11. Marital Status		1	2. Was Decede Armed Force	nt Ever in U	.S. 13.	Was Dece If Yes, spe	dent of H	ispanic O an, Mexica	rigin? (Sp an, Puerto	ecify Yes or I Rican, etc.)	No-		- Amer	ican Indian	١,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or Iteme 23a or 28a-f ehow appropriant: If item 27 ie marked other than "natural", or Iteme 23a or 28a-f ehow appropriately injury or other traumatic avent, Ira Madical Examinar must be notified at once.	by	1X Never Mar 3 ☐ Widowed			1 ☐ Yes 23 If Yes, Give Year or Date		j.	1 🗆 Yes		Specify				Specify:			
5-0	72 h	etec	(Spe	15. Deceder				(Give	dent's Usu kind of wo	ork done	during mo	st of work	ing	16b.	Kind of Bu	siness/lr	ndustry	
121	within ne.	Completed	Elementary/Sec	ondary (0-12)		College (1-4	or 5+)		<i>DO NOT u</i> 'sing			+		Но	alth	Care	<u>, </u>	
2	Hygie ther t	e ငိ	17. Father's Name	(First, Middle,	Last)			Nul	Sing	NSS.			e (First, Mida					
an	ld be ental ked o	To Be		riah I		ı					Gre	tlin	e Bro	wn				
Maryland	shou nd M mer		19a. Informant's N					19b. Maili	ng Addres	s (Street	and Numi	ber or Rur	al Route Nun	ber, City	or Town, S	State, Zi	p Code)	
Σ	alth a alth a 27 le		Hillary	Allwoo	d (I	Daughter	<u>:</u>)	1836	Metze	erott	Rd.	#120	2 Adel	phi,	hi, Md. 20783			
nore	nt of He		20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Bethel United Church											High	Location · (,St.		e
Baltimore,	ermit. P epartme nportan ny Injur		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chambers Funeral Home & Crement Chambers Chambers Chambers Funeral Cha												amaic toriu		. A .	
	₫ O E # 0		111.7	W-W	las	neer	au		301 C.	Leve_	Land	Ave.	River	<u>dale</u>	, Md.	207	/3/	
-66	Physician		23a. Part1. Enter shock, or he Immediate Cause disease or conditi	art failure. List (Final		e cause on eac	n line.	Chain		_ ′					Prist	,		Between nd Death
	/Medical		resulting in death)		•	Due to (or	as a consec	quence of):	<i>-</i> , , , ,			VAGO	C.0-7	Q - Q	200			
346	Examiner	4	Sequentially list of any, leading to it	onditions,	b		as a consec	uence of):										
	uted Insit	Examiner	cause. Enter Und Cause (Disease of that initiated event	erlying r injury	₹	220 10 (0.		120.100 0.7.										
oʻ	exection and jal-tra	Еха	resulting in death)	Last	C.	Due to (or	as a consec	quence of):									_	
9289	ysicia ysicia	-			C d													
99	ng ph	Med	JF FEMALE:		1													
P.O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the buriat-transit	Physician/Medica	23b. Was decede in the past 1: 1 Yes 2 9 Unknow	2 months?	23	3c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	2 Feta	af death 3[⊒Ectopic p ⊒ Other (s _i		,				23d. Date Mon		rery Day	Year
	that hed by deta	y Ph	Part II. Other sign	ificant conditi	ons con	tributing to deat	h but not res	sulting in the u	ınderlying	cause giv	en in Part	f.	23e. Di	tobacco	use contri	bute to	the cause	of death?
rds	w requires been sign should be	q pa	End Hz	upe the	una	DHEE	ite 1	terio	the re	OV	750	slav	10	Yes 2	2 🗆 No	3 □ P ro	bably 4	⊡bnknown
Records,	aw re	Completed by	Diseas	e Bil	at-	enal.	4500	relan	ae a	my	SUT	200	24a. W	as an	24b. W	/ere aut	opsy findir	ngs available
Ä	The late happened	E	anoxu	gulen	4910	DG The	Veut	sluto	- De	be	1/4		pe 1 Yes	rformed?	d d	eath?	2□ No	of cause of
/ita	cian: artific actor,	Be (25. Was case refe examiner?	erred to medica	_	7						ce of Deat	h (Check onl	у оле)				
of Vital	hyeic this c	우	1 ☐ Yes 2 ☑		Н	ospital: 1 ☐ Inp		FR/Outpatie			4 🗇 ۲	lursing Ho	ome 5 Ae				fy)	
	fing F	lon	27. Manner of Dea 1 Natural	5 Pendi		28a. Date of (Month,	njury Da <i>y</i> Ye <i>ar)</i>	28b. Time o Injury	M	28c. Injur Wor	yat k? Yes 2[TNo.	28d. Describ	e how inj	ury occurre	ed .		
Division	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident 3 Suicide 4 Homicide	6 ☐ Could		28e. Place of building	Injury - At h	ome, farm, st			703 2	1140	28f. Location City or 7	(Street a	and Numbe	or Rui	al Floute N	Number,
Ω	pital o		29a. Certifier	1D Certifui	na Phys	ician: To the be	set of my kn	owlodge des	th annumer	d at the tir	no data :	and place	and due to th	2 221152	c) and may	nor no	otatad	A. T
	the Hospital nin 24 hours the Funeral I npletely filled	Medical	(Check only one)	2 Medical	Examin	er: On the basi and manner	s of examina	ation and/or in	vestigation	n, in my o	pinion, de	ath occur	red at the tim	e, date a	nd place, a	nd due	to the caus	
		Σ	29b. Signature an	d title of certifie	er 1	1	, ,		3 `		number و				ate signed			
	3		100	me	lis	Mu	re	und		יסנ	183	1 2		res	bhu	This	27	2006
			30. Name and add	dress of person	who co	ope M	of death (Ite	m 23a) (Type	, Print) ノピー	4561	199	Pol A	MATE	Suil	one	20	378	2006
	Sta Registr		31. Date filed (Mo	nth, Day, Year MAR 0		32. 8	istrar's Sign	ature A	Segali.	9								

DHMH 17 Rev 1/2001

		•	For State Registrar		State of Ma	•	epartment of I Certificate of			giene Reg. Ne. 🔒 🎧 💪	10055
	Physicia	an	1. Decedent's Name			NI I			2. Date of De Month	Day Ye	3. Time of Death
	/Medic		4a. Facility Name (If	LORE	S. L(JW	4b. City. Town,	or Location of Death	MARCH	1, 2006	
	Examin	er		LLE NURS				VILLE		MONTGOM	
	Funeral		5. Social Security Nu	mber 6. Se	7. Ag	e (In yrs. last birt	hday) If Under 1 Year Months Days		8. Date of Bir (Month, Da		Birthplace (State or Fore Country)
	Director		216-28-47 Usual Residence of I	61	□M 21 X F	82	Yrs.		JULY 21	, 1923	GERMANY
	land ow			10b. County		10c. City, Town	or Location				10d. Inside City Lim
	Mary a-f sh	tor	MD.	MONTGOME	RY		BETHESDA				1 X Yes 2 □ 1
	th the	Director	10e. Street and Num	ber			10f. Zip Code			10g. Citizen of Wha	t Country?
	ath wi		6520	CALLAN	DER DR.			817		U.S.	
9	d within 72 hours after death with the Maryland jene. Ir than "natural", or liems 23s or 28s-f show the Madical Examinat must be notified at	/ Funeral	11. Marital Status 1 Never Marrie		12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑! If Yes, Give		13. Was Decedent of lif Yes, specify Cub 1 ☐ Yes 2 🔀 No		pecify Yes or No Rican, etc.)	Specify:	American Indian, White, etc.
3	ural',	d by	3 ₩ Widowed 4		Year or Dates:						WHITE
Ÿ	n 72 l	ompleted	(Specif	15. Decedent's Ed fy only highest grad	de completed)		Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of work	king	16b. Kind of Busin	ess/Industry
21215-0036	within iene. than	omp	Elementary/Secon	idary (0-12)	College (1-4or 5	5+)	COMPTRO			WGMS RAD	010
ō	othe ent,	e C	17. Father's Name (F	First, Middle, Last)				Τ .	ne (First, Middle	, Maiden Sumame)	
lar	2 should be and Mental Is marked craumatic ever	To B		SIEGFRIE	D SALO	OMON		FRI	EDA	MATTHIAS	•
Maryland	and has and has ma		19a. Informant's Nar				Mailing Address (Stree			-	
≥,	and ealth m 27				TTI/DAUGH		355 QUINCE				
altimore,	Per ite		20a. Method of Dispo		Removal from State	20b. Place of cemeter	Disposition (Name of y, crematory or other pla	ice)	Date	20c. Location - City	,
턡	t. Partmen			5 Other (Specify		CHAMBE	RS CREMATOR			RIVERDAL	
Bal	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injuryor other traumatic evonce.		21. Signature of Fun	AL C	rambe	used	CHAMBERS I 5801 CLEVE	UNERAL HOLLAND AVE.	ME & CE	REMATORIUM RDALE, MD.	P.A. 20737
			23a. Part1. Enter the shock, or hear	e disease, or comp t failure. List only	olications that caused one cause on each li	i the death. Do r ne.	not enter the mode of dy	ng, such as cardiac	or respiratory a	urrest,	Approximate Interval Between
	Pnysician	8 4	Immediate Cause (F	Final	a CEREBRO	OVASCULA	R ACCIDENT				Onset and Death
	/Medical Examiner		resulting in death)			a consequence of	-				
	- Adminion	e	Sequentially list con	ditions.		ENSIVE H	EART DISEAS	SE			<u> </u>
	ted nsit	nlne	cause. Enter Under Cause (Disease or in	lying njury			DISEASE				
	be executed sician and burial-transit	Examin	that initiated events resulting in death) Li	ast	0.	a consequence of					
68760,	ficate be executed g physician and is the burial-transit	edical		l	d						
		led	IE EEMALE.								
Вох	law requires that the death certifias been signed by the attending 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome 1 ☐ Live birth	of pregnancy 2 Fetal death	3 ☐Ectopic pregnanc	ey .		23d. Date of Month	f delivery Day Year
	at the dea by the at tached fo	sici	in the past 12 r 1 ☐ Yes 2 🔀 9 ☐ Unknown		4□Pregnant at 9□Unknown	time of death	5 Other (specify)			Wichter	Day Tour
P.0	that the			cant conditions co	ontributing to death b	ut not resulting in	the underlying cause g	ven in Part I.	23e. Did t	tobacco use contribu	ite to the cause of death?
ds,	signe d be	d by			•	-	,,,		1 🗆	Yes 2□No 3[Probably 4 Nunkno
Vital Records,	w requir been si should	ompleted							24a. Was	an 24b. Wer	re autopsy findings availa
Re	The lar	dmc							auto	psy prior deat	r to completion of cause of the completion of the completion of the cause of the ca
tal	ician: T certificat rector, pa	C	25. Was case referre	ed to medical				26. Place of Dea	th (Check only		Yes 2 No
<u> </u>	S S S	To B	examiner? 1 ☐ Yes 2 X N	No	Hospital: 1 Inpatie	ent 2 ER/Ou	tpatient 3 DOA	han		idence 6 Other ('Specify)
n of			27. Manner of Death	5 Pending	28a. Date of Inju	ry 28b. T	Time of 28c. Injury Wo	ry at ork?	28d. Describe	how injury occurred	
<u>S</u>	Attending r death. ector: Afte by the fune	catle	2 Accident	investigation]Yes 2 ☐No			
Division	after death Director:	Certification:	3 Suicide 4 Homicide	determined	28e. Place of In	ury - At home, fa c. (Specify)	rm, street, factory, office			(Street and Number o wn, State)	or Rural Route Number,
1	Hospita 4 hours Funeral	edical Ce			niner: On the basis of	f examination and	, death occurred at the t d/or investigation, in my				
	To the within 2 To the complet	Med	29b. Signature and	title of certifier	and manner st		29c. Licen	se number		29d. Date signed (A	Month, Day, Year)
	/			Inom	10 V	Posus	N/A D/	7330		MARCH 1,	2006
	φ		30. Name and addre		completed cause of c		D-	., 550		IIIIIII I)	
			THOMAS		SEPH, M.D	. 50 W	. EDMONSTO	N DR. #207	, ROCK	VILLE, MD.	20852
	Sta		31. Date filed (Mont	h, Day, Year)		ar's Signature					
	Registi	ar	MA	AR 03 20	106	U 15 1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** ALBERT LAWRENCE LAUER SR. 2006 10:27 AM MARCH 1 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MONTGOMERY OLNEY MONTGOMERY GENERAL HOSPITAL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 6. Sex Birthplace (State or Foreign Country) **Funeral** Min Months Days Hours 1 XM 2 □ F 577-10-5247 89 Director 1916 Washington, D.C. Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Important: if itam 27 is marked other than "natural", or Itams 23a or 28a-1 show any jury or phare traumatic event, the Medical Eraminat must be notified at once. 1 ☐ Yes 2 No Md. Olney Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Old Baltimore Court 20832 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: þ WWII White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Auditor Federal Court 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Adam Lauer Abbie Ann McKimmie ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) S. Lauer / Wife 2 Old Baltimore Court, Olney, Maryland 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven 3/6/06 4 □Donation 5 ☑ Other (SpecifyEntombment Silver Spring, Md. 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee W. Bark 20882 Box 5038, Laytonsville, Md. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final **Physician** CAD disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** HTN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit DEMENTIA the attending physician and Due to (or as a consequence of): HIGH CHOL. Physician/Medical d. as IF FEMALE 950 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed 1 ☐ Yes 2 No 1 🗌 Yes 2 No Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: P 2 X No 1 Yes 1 🔲 Inpatient 2 KER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Certification: Injury at Work? After Hospital or Attending 5 Pending investigation 1 Natural М 1 🗌 Yes 2 No death. 2 Accident after death Diractor: filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital of within 24 hours at To the Funeral D 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MARCH 2, 2006 0056132 D 12+1 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

NARITA SURANA, M.D.

0 3 2006

31. Date filed (Month, Day, Year)

MAR

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Registrar's Signature

4000 OLNEY-LAYTONSVILLE ROAD,

OLNEY, MD.

20832

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Beverly Joyce Laur 2006 9:50 p March 3, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll 150 Sullivan Road Westminster 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday, Funeral Days Hours 1□ M 2🙀 F Yrs. 217-38-8722 Director Jul 10, 1941 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28a-f show the Mazical Examiner rust be notified at Westminster Carroll 1 ☐ Yes 2 No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 USA 150 Sullivan Road r death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours efter Hygiene. other than "natural", or ite 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8 other permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: if Item 27 is marked other any injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Howard Schultheis Evelyn Marie Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 150 Sullivan Road, Westminster, MD 21157 Deborah M. Zamencki, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Finksburg, MD 03/07/2006 Evergreen Memorial `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licensee 91 Willis Street, Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Julms som Immediate Cause (Final disease or condition resulting in death) Priysician /Medical quence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-transit 1Whosh Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months?
1 Yes 2 No 4☐ Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown 9 Unknown been signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 (**36**)0 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death, To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) npletely and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) COU D0037728 MIL 3-6-06 30. Name and addrass of Jerson who completed cause of death (Item 23a) (Type, Print) 2 LEE- YOUNG, MI Arenen 216A Washington Hgts Westminster, MD 21157 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Stown B. Sperke Registrar

Chake of Manufacad i	Department of the although	and the state of the section of
State of Maryland /	Department of Health	and Mental Hydlene

	For	State of Maryland / Department of Health and M	le
-	State Registrar	Certificate of Death	
_	Secondant's Nome /First	die Lees	_

iygici	10				
Reg.	No.	15	00	25	1

			- Hegistrar		00/	inouto or	Douth		Heg. No.	117	00600
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Year	3. Time of Death
· ·	/Medic		Cyn	thia Jean Mears	3			March	10	2006	4:30 P ^M
A.	Examin	er	4a. Facility Name (If not institution, give :	street and number)		-	r Location of Death			y of Death	
			Sinai Hospital			Baltimo		T I	N/A	T-1	
	Funeral		5. Social Security Number 6. Sex	TM 2675	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir Month Da DEC 23	th ly, Year)	Coun	
	Director		221-58-7383	[™] ² X ^r 45	113.			DEC 23	, 1900	wasnii	ngton, D.C.
	and		10a. State 10b. County	10c. City, T	own or Loc	ation				1	0d. Inside City Limits
	Mary 1 ehe	ō	Maryland Cecil	E1k	ton						1∭Yes 2☐No
	28a	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	itry?
	with 3a or	by Funeral Director	103 Danford Driv	r 👝		21921				ed St	-
	ne 2;	era		12. Was Decedent Ever in U.S.	13. W	Vas Decedent of H	lispanic Origin? (Sp	pecify Yes or No		ce - Americ	
(0	riter	교	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No			an, Mexican, Puerto	Rican, etc.)	Bla	ick, White,	etc.
ဇ္ဇ	al', o	by	3 ☐ Widowed 4 📆 Divorced	If Yes, Give A Year or Dates:	1	☐Yes 2M2No	Specify:		Specia	^{∱∵} Whi	te
9	72 ho	Completed	15. Decedent's Edu (Specify only highest grade	cation 1	6a. Decede	ent's Usual Occup	pation	cina	16b. Kind of B	Business/Inc	dustry
2	thin thin	nple	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of work d)	, g		_	
7	ygien Agrien Agrith	Con	12		Sel:	f-Employe					provement
D	tal Hy d oth	Be	17. Father's Name (First, Middle, Last)	_			18. Mother's Nam				
<u>×</u>	Men Men arke	ဥ	Gerald Eugene Da						1 Clage		
a	2 sh and le m) I	19a. Informant's Name/Relationship (Ty				and Number or Rui				•
2,	and ealth m 27		Frances C. Gille			the second second second	Drive, E1				
ore	r of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ P	Removal from State	tany cram	sition (Name of natory or other plac TIS & CO		h 16,	West C	heste	wn, State Y,
Ë	men tant:		4 □ Donation 5 □ Other (Specify)	l Inc.			200		Pennsy		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service License	e thike	Hi 10	Name and Addre cks Home 3 W. St.o	e for Fund ockton Sti	erals, I	A. kton. N	Marvla	and 21921
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the death.							Approximate Interval Between
	Physician		Immediate Cause (Final	0 1	- A	KrhyT	h wina.				Onset and Death
d.	/Medical		disease or condition resulting in death)	Due to (or as a consequen	ce of):	1.116411	- Cuca				·- · · · · · · · · · · · · · · · · · ·
	Examiner			Hemon	has	e					
7		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequent	ce of):		1				
V	cuted nd ransi	Examiner	Cause (Disease or injury that initiated events	Due to (or as a consequent	elis	worau	, Avter	4 In	wy		
o	e exe ien a urial-		resulting in death) Last	Due to (or as a consequent	ce of):		,	/	7		
Box 68760,	The law requires that the death certificate be executed ate has been signed by the ettpnding physicien and page 2 should be detached for use es the burial-transit	an/Medical		Right I	Ne	umone	ctomi	1			
9	artific ing pl	Mec	IF FEMALE:				,				
90	ath ce ttand or us	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de	ath 3 🔲	Ectopic pregnancy	/			ate of delive onth	ny Day Year
	the e	sic	1 ☐ Yes 2 ☐ No 9 XX Unknown	4☐Pregnant at time of death 9☐Unknown	5□	Other (specify)					
P. 0	ires that the death signed by the etts d be detached for	Physici	Part II. Other significant conditions cor	atributing to death but not resulting	a in the un	derlying cause giv	en in Part I	23e Did t	ohacco use con	tribute to th	ne cause of death?
ds,	signe d be	2	Non Small (ellcarcinone	_	una	or are a	10	10		ably 4 □Unknown
0	w require been si should I	etec	100000000000000000000000000000000000000	Cit Chev Cer 4 11	0	7		-			
3ec	elaw hasi	Completed						24a. Was	an 24b. osy ormed?	were autor prior to cor death?	psy findings available inpletion of cause of
<u> </u>	icate								2 □ No	1 🗚 Yes	2 No
ŽΞ	Physiclan: rthis certificand in this certificand in the central director, in the central directo	Be	25. Was case referred to medical examiner?	lospital:		3□ DOA Oth	26. Place of Dear				8086
Division of Vital Records,	Phys rthis raldi	Ţ.	1 X Yes 2 No	1 Linpatient 243EH	Outpatient b. Time of	3LI DOA	# [] Nuising no		dence 6 Otl		/)
on	Attending ir death. ector: After by the funer	ton	1 □ Natural 5 □ Pending 2 🕅 Accident Investigation	(Month, Day Year)	Injury	28c. Injur Wor M 1 🗆	k? Yes 2 ☑No	r	aopeia	tive:	Injuryto
S	Atten deal ctor: y the	flca	3 Suicide 6 Could not be	28e. Place of Injury - At home	. L -			28f. Location (Street and Num		I Route Number,
ă	after Dire	Certification;	4 Homicide determined	building, etc. (Specify)				City or To	vn, State) 24	101 W	.Beledere
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Phys	sician: To the best of my knowled	dge, death	occurred at the tir	ne, date and place,	and due to the	cause(s) and m	anner as st	ated.
	n 24 n 24 ne Fu	edical	(Check only 2 Medical Examinations)	ner: On the basis of examination and manner stated.	and/or inv	estigation, in my o	ppinion, death occur	red at the time,	date and place,	and due to	the cause(s)
	To ti withi To ti comp	ž	29b. Signature and title of certifier	e nome of		29c. Licens	e number		29d. Date signe	ed (Month,	Day, Year)
	^		Carrella	llau ned		OCI	ME		March	12,	2006
	. 1		30. Name and address of person who co	ompleted cause of death (Item 23	a) (Type, F		nn Street	Ro1++	more M	artil 0.	nd 21201
			1/1 K J/(. /T · /\/			TTT 151	ロコ ひしてこにし	DCL	III LE . I'll	ณางเสเ	NJ 41401

State Registrar 31. Date filed (Month, Day, Year)
MAR 1 7 2006

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Mary		artment of F			ene No.UU6	03259	
	Physici /Medi		1. Decedent's Name (First, Middle, Last) AM ES	M° C	-ULL DU	GH		2. Date of Death Month	Day 4	3. Time of Death	1
1. 1.27	Examir		4a. Facility Name (If not institution, give st. Anne Arundel Medica	reet and number)		4b. City, Town, o	r Location of Deat	h	4c. County of	Death Arundel	
*	Funeral Director		5. Social Security Number 6. Sex 18		yrs. iast birthday) 2 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y July 7,		9. Birthplace (State or Foreign Country) Georgia	n
	Maryland s-f show fied at	tor	Usual Residence of Decedent 10a. State 10b. County MD Anne Arund		lc. City, Town or Lo		hian			10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	with the	I Director	10e. Street and Number 23 A Street			10f. Zip Code		10g	. Citizen of Wh	nat Country?	
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itam 27 is marked other then "natural", or iteme 23a or 28e-1 show other treumatic event, it a Medical Eventher require	by Funeral		. Was Decedent Eve Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 19		Was Decedent of Hif Yes, specify Cuba	lispanic Origin? (S	Specify Yes or No- to Rican, etc.)	14. Race -	American Indian, White, etc.	
Maryland 21215-0036	e filed within 72 ho al Hygiene. other then "natur vent, Le Medical	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired Cklayer	during most of wo	rking 16	b. Kind of Busi		
yland ?	2 should be filed and Mental Hygis is marked other eumatic event, II	To Be C		cCullough			Minni		_{iden Sumame)} Lanier		
	iges 1 and 2 st nt of Health and : If item 27 is n or other treun		19a. Informant's Name/Relationship (Type Marjorie I. McCullo 20a. Method of Disposition 1 □ Buriai 2 ☑Cremation 3 □ Rei	ough, wife	23 A	Street,	Lothian,			rate, Zip Code)	_
Baltimore	permit. Pages Department of I Important: If its any injury or of		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee			2. Name and Addre	ss of Facility	25/06 <i>I</i>		ria, VA , MD 20736	_
8760,	Physician on /Medical Examiner and physician and physician and the pritarist the pritarist that the pritaris	dical Examiner	23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	cause on each line.	insequence of): A insequence of): Y A Y A Y A Y A Y Y A Y	er the mode of dyir Aspend Leur	ng, such as cardia	c or respiratory arrest		Approximate Interval Between Onset and Death	
.O. Box 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	i. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of Month		
ords, P	v requires that been signed b should be deta	ted by PI	Part II. Other significant conditions contr	buting to death but no	ot resulting in the u	nderlying cause giv	en in Part I.			ute to the cause of death?	1
al Records,		Completed						24a. Was an autopsy performed	d?_ dea	ore autopsy findings available or to completion of cause of ath?] Yes 2 □ No	,
Division of Vital	ding Ph h. After th funeral	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 Ho 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	spital: Inpatient 28a. Date of Injury (Month, Day Ye		28c. Injur Wor M 1	er: 4 Nursing H	tth (Check only one) lome 5 Residenc 28d. Describe how	injury occurred		_
DİV	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer		4 Homicide determined	28e. Place of Injury - building, etc. (S	pecify)			City or Town, S	State)	or Rural Route Number,	
	To the Hospital or within 24 hours after To the Funerel Diracompletely filled in I	Medical	29a. Certifier (Check only one) 29b. Signature and fittle of certifier	r: On the basis of exa and manner stated.	mination and/or inv	vestigation, in my o	pinion, death occu	rred at the time, date	and place, and	er as stated. d due to the cause(s) Month, Day, Year)	
	F S F 5		A)A UL 30. Name and address of person who com	Police of death	Way Gu	n [21438	F-	elsry	ry 24 2000	
1	0+1 Sta	to	Macc 16 1201 11 1	32. Registrars	VEFER	STH 6H	WAY AN	NAPOUS	MDZ	1401	
	Registr	-	MAR - 1		ener H.	boutes)				

PAT

MCGHEE

			1 - For 1 - State Registrar	State of Maryla	nd / Depa		of He	alth an	•			08261
	Physici /Medio		Decedent's Name (First, Middle, L Lawrence		zuchow	ski			2. Date of De Month March	Day	y Year . 2006	3. Time of Death 8:15A
	Examir		4a. Facility Name (If not institution, gr			4b. City, To	own, or Lo	ocation of D			County of Deat	h
	Funeral Director			Sex 7. Age (In yr.	s. last birthday) Yrs.	If Under 1	Year I	f Under 24 I Hours N	Hrs. 8. Date of Bin Min. (Month, Da anuary	y, Year)	9. Birt Co	hplace (State or Foreign untry) WYOTK
	Maryland -f ehow lied at	tor	10a. State 10b. County MD Char		City, Town or Lo							10d. Inside City Limits 1 Yes 2 □ No
	with the	Director	10e. Street and Number 114 Thomas Je			10f. Zip C	646			10g. Cit	izen of What Co	untry?
36	be filed within 72 hours after death with the Maryland stal Hygiene. So other then "natural", or Items 23e or 28e-1 ehow event, if a Medical Examinational be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1X Yes 2 □ No If Yes, Give	U.S. 13.		nt of Hisp y Cuban,	anic Origin? Mexican, Pi	? (Specify Yes or No uerto Rican, etc.)	-	USA 14. Race - Ame Black, White Specify: V	
21215-0036	within 72 hour ene. then "natural" he Medical Ex	Completed b	15. Decedent's 8 (Specify only highest g.		(Give	dent's Usual (kind of work DO NOT use	done dur	on ing most of	working	16b. Ki	ind of Business/	
	d be filed wil ntal Hygien ed other th	Be	17. Father's Name (First, Middle, Las	5+	Te	acher	18	B. Mother's Pearl	Name (First, Middle,	Maiden	ddle S Sumame)	School
, Maryland	ges 1 and 2 should but of Health and Menta If item 27 le marked or other traumetic er	To	19a. Informant's Name/Relationship Kelly Foster/			-	Street and	d Number or	Maskee Rural Route Number 1kner, MI	r, City o		(ip Code)
Baltimore,	permit. Pages 1 are Department of Heal Important: If item eny injury or other poce.		20a. Method of Disposition 1 → Burial 2 → Cremation 3 1 → Donation 5 → Other (Spec	□Removal from State ify) T1	Place of Dispo cemetery, crei	Memo:	_{er place)} rial	Gar	Date 3/6/06	Wa	ocation \cdot City or $1 ext{dorf}$,	Maryland
Ball	Depart Import eny in		21. Signature of Funeral Service Lice 23a. Part1. Enter the disease, or cor	90092 M0092	15 22	Name and AREHA	Address (of Facility ECHOL	S FUNER	AL I	HOME, P	.A.
	Priya iciair /Medical Examiner pnuish (Lausi) Pnuis	Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, fary, leading to minediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	equence of): User quence of): ual	Card	llst	arri	la dise	se		Interval Between Onset and Death
.O. Box 68760,	death certificate e attending phy: id for use as the	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of	tal death 3]Ectopic preg] Other (spec					23d. Date of deli Month	very Day Year
s, P	requires that the een signed by th hould be detache	by	Part II. Other significant conditions	contributing to death but not re	esulting in the u	nderlying cau	se given	in Part I.		bacco u es 2[_	the cause of death?
al Record	The lar ate has page 2	Completed									prior to death?	topsy findings available completion of cause of
Division of Vital	ding Phye h. After this funeral di	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c	Other: Injury at Work? 1 \(\text{Yes}	4 🗌 Nursin	Death (Check only of g Home TY Resid 28d. Describe h	lence (y occurred d Number or Ru	ral Route Number,
_	To the Hospital or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my kilminer: On the basis of examinand manner stated.	nowledge, death	n occurred at vestigation, in	the time, my opini	date and pla ion, death o	ace, and due to the courred at the time,	ause(s) date and	and manner as I place, and due	stated. to the cause(s)
	To the I within 2: To the I complet	Me	29b. Signature and title of certifier	Vafar		29c. L	icense n	umber 574		29d. Dat	se signed (Month	n, Day, Year)
	SB 10 ! 1		30. Name and address of person who Timothy Pace,	M.D. 12070	01de T	ine (Cent	re,Wa	aldorf,M	d 2	0603	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 3	2006 32. Egistrar's Sign	Lature A	barte						

		1 - For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of H rtificate of I		-	giene Reg. No.	5 0	3262
Physicia /Medic	al	NAOMI P. 4a. Facility Name (If not institution, give	MORRIS		Ab City Tourn or	Location of Death	2. Date of De. Month	Day 2	Year 2006	3. Time of Death M 4:45 AM
Examin	er	Genesis Health		no Dinos					Talbo	.+
Funeral Director		5. Social Security Number 6. Se		(In yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da 6 / 25 / 1	th v. Year)	9. Birthp	place (State or Foreigr ntry) yland
		Usual Residence of Decedent					0/23/1	712		
naturel', or items 23a or 28e-f ehow iteal Examinar must be notified at	tor	10a. State 10b. County 10b. Tall	oot	10c. City, Town or Lo	Easto	n			1	0d. Inside City Limits 1 XYes 2 No
r 28e	Irec	10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Cour	ntry?
23a c	alD	610 Dutchmans	Lane		216	01		Unit	ed St	ates
"naturel", or items 23a or 28e-f ehow idical Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	0	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 24☐XNo	spanic Origin? (Sp n, Mexican, Puerto Specity:	pecify Yes or No Rican, etc.)	BI	ace - Americ lack, White, city: Wh:	etc.
dical	ted	15. Decedent's Edu	ıcation	16a. Dece	dent's Usual Occupa	ation		16b. Kind of	Business/Inc	dustry
Ine Mis	Completed	(Specify only highest grade Elementary/Secondary (0-12) 1 2	College (1-4or 5-	+) life.	kind of work done of DO NOT use retired	rk		Yale S	Sport	g Store/ swear
c event.	Be	17. Father's Name (First, Middle, Last) Joseph Hall F	ovner			18. Mother's Nam	e <i>(First, Middl</i> e, E. Gam		ame)	
traumetic	은	19a. Informant's Name/Relationship (T		19b. Mailir	ng Address (Street a				n, State, Zip	Code) 21655
other trai		Rosalie F. Dudr	ow/Daugh							
or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State		natory or other place	θ)	Date	20c. Location	n - City or To	own, State
jury		* 4 ☐ Donation 5 ☐ Other (Specify)		Woodlaw	n Cemet	ery 3/4	/2006	East	on, M	aryland
eny injury or o once.		21. Signature of Funeral Service Licens	m. C	vale F	. Name and Addres	Funera			erals	
ician dical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on sich lin	the death. Do not ent e. diomy of C	er the mode of dying	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
iiner	16	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence (1):	<i></i>				0	years
s the burial-transit	I Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Ather	osclerosis consequence of):					j	gears
	n/Medical	IF FEMALE: 23b. Was decedent pregnant	d				-	23d. D	Date of delive	ery
detached for	Physician/M	in the past 12 months? 1 ☐ Yes 25 No 9 ☐ Unknown	1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown		Ectopic pregnancy Other (specify)			N	Month	Day Year
should be det	by	Part II. Other significant conditions co	ntributing to death bu	t not resulting in the u	nderlying cause give	on in Part I.		obacco use co res 2 🗆 No		ne cause of death? nably 4 Unknown
pagez	Completed						24a. Was autop perfo 1 \(\text{Yes} \)		prior to cor death?	psy findings available mpletion of cause of 2 No
director,	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Deat				
<u>0</u>	: To	1 ☐ Yes 2 XNo	28a, Date of Injun	28b. Time of	t 3 DOA	4 Nursing Ho	ome 5 Resident			y)
e fune	atior	1. Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury	28c. Injury Work M 1 🗆 Y	? /es 2 □ No				
ad in by ir	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc.	ry - At home, farm, str . (Specify)	eet, factory, office		28f. Location (S City or Tox		nber or Rura	il Route Number,
ely fill	edical	29a. Certifier (Check only one) Certifying Phy 2 Medical Exami	sician: To the best o ner: On the basis of and manner stat	f my knowledge, death examination and/or in ed.	occurred at the tim restigation, in my op	e, date and place, inion, death occur	and due to the cred at the time,	cause(s) and n date and place	nanner as st e, and due to	tated. the cause(s)
сотріе	M	29b. Signature and title of certifier	V 1		29c. License	number	2.19	29d. Date sign		
		114A	1001/	Set 1		12599	ク	3	5. Z.O	6
	25	30. Name and address of person who complete CROWLE	ompleted we of de	m	Print) (LANC	EAST	TON, M	a CIC	21601
Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	Land P					

Naomi Morris

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1	4		1 - For State Registrar		Stat	e of Ma	arylar		artmen rtificat				lental Hy	giene Reg. No.	16	08263
#	Physic	ian	1. Decedent's Name (First, Mic	die, Last,)								2. Date of De Month	ath Day	Year	3. Time of Death
	/Medi		Carol	J.			N	linnick					03	-08	00	2300 M
	Examir	ner	4a. Facility Name (If not institut	ion, give	street an	nd number)	1 - 1		4b. City,	Town, or	Location of	of Death			ity of Death	
			5. Social Security Number	CARH 6. Se	t M	10SD1	tal	last birthday)	If Under) M C 1 Year	If Under	21 Hrs	8. Date of Bir		eGA	
e.	Funeral Director		220-28-7623		M 2	7	73	Yrs.	Months	Days	Hours	Min.	Jun 28	, °f932	Col	nplade (State or Foreign
			Usual Residence of Decedent								1					
	show	-	MD AII	egan	nv		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
	Ba-f	ecto		- Gui	· y								·			1 Yes 2X No
	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23e or 28e-f show avent, the Madical Exeminer must be notified at	Funeral Director	300 National I	-liah	May.	Ant A			10f. Zip		21502	2		10g. Citizen o	f What Cou JSA	untry?
	eath	erai	11. Marital Status			Decedent		IS 13 1	Was Decer				acifu Vas or No			ncan Indian.
(0	r then	Fun	1 Never Married 2 M	i	Arme	ed Forces? Yes 2 1				V	n, Mexican	, Puerto	ecify Yes or No Rican, etc.)	В	ack, White	
8	ours a	þ	3 ☐ Widowed 4 ☐ Divorc		If Ye	s, Give or Dates:			1 □ Yes	2☐No	Specify:			Spec	ify: wh	ite
5-0	72 ho	Completed by	15. Deced (Specify only high	ant's Edu	cation e comple	eted)		16a. Deced (Give life.	dent's Usua	al Occupa	ation	t of worki	na	16b. Kind of	Business/I	ndustry
21	within ene. then "	npi	Elementary/Secondary (0-12			ege (1-4or 5	+)			e retired)	. 0	9	self-en	anlove	od
2			17. Father's Name (First, Middle	la / anti				seams	511622		40 M-45-	-l- Nt	(F) - A B - I - II			
anc	should be filed nd Mental Hygi marked other imatic avent, I	Be	Spurgeon C		aner								o (First, Middle, oughen			
Maryland 21215-0036	d 2 s h ar 7 ls trau	7	19a. Informant's Name/Relatio	nship (Ty			and	19b. Mailir 300	Natio	(Street a	My.	or or Aura Apt.	A LaVa	r, City or Tow	n, State Z	D°21502
re,	es 1 and 2 of Health fitem 27		20a. Method of Disposition				20b. I	Place of Dispo	sition (Nam	ne of	el		ate	20c. Location	n - City or T	Fown, State
E			1 ☐ Surial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		lemoval	from State	Re	stlawn V	lemoria	al Gai	dens		3/13/2006	LaVa	le	MD
Baltimore,	permit. Pag Department Important: any injury c		21. Signature of Furneral Service	e License	90	Ma	100	D- 22					ome, PA e: Cumbe	rland, Mi	D 2150	2
	× 1		23a. Part1. Enter the disease, shock, or heart failure. Li	or compli	ications t	that caused	the deal	th. Do not ent	er the mode	e of dying	g, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition					in last			A E	10				Onset and Death
- 46	/Medical		resulting in death)		a Du	e to (or as			1-12		+/(10	<u> </u>			56
	Examiner		Sequentially list conditions.		o											
,	be iii	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	2	Du	e to (ur as	a consec	uence of):								
/_	ate be executed thy sician and the burial-transit	Examiner	that initiated events resulting in death) Last	c		e to (or as	a conser	mence of):			-				-	
8760,	be e. sician buria			Ι.				1401100 01).								
687	ficate physics first first	edic			J											
Box	death certificate be executed e attending physician and id for use as the burial-transi	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	2		s, outcome								23d D	ate of deliv	/Anv
	death e atte d for	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No		4 □ F	ive birth. Pregnant at]Ectopic pre] Other (spe						lonth	Day Year
P.O.	t the by th ache	hys	9 □ Unknown		9[](Jnknown ———										
	Se un eg	by Р	Part II. Other significant condi	tions con	ntnbuting	to death bu	ıt not res	ulting in the ur	nderlying ca	ause give	n in Part I.					the cause of death?
ord	w requires been sign should be												1 🗆 Y	es 2 🗆 No	3 🗌 Pro	bably 4 Unknown
ပ္မွ	aw Is b	Completed											24a. Was autop		. Were auto	opsy findings available empletion of cause of
<u> </u>	Th ate pag	Con											perfo	med? 2 ☑No	death?	2 □ No
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medic examiner?	·								of Death	Check only o			
5	Physical this of all directions of the control of t	ို	1 ☐ Yes 2 ☐ No	Н	-	1 Inpatie		ER/Outpatien			4 🗆 1901	rsing Hor	ne 5 Resid	ence 6 🗆 O	ther (Speci	ify)
u C	Jing After fune	lon	27. Manner of Death 1 ☑Natural 5 ☐ Pend		28a. L	Date of Injur Month, Day	Year)	28b. Time of Injury		Bc. Injury Work			28d. Describe h	ow injury occu	irred	
<u>S</u>	or Attanding after death. Director: After in by the fune	Ica	3 Suicide 6 □ Coul		290 5	Place of this	ini - At hi	ome, farm, stre	M .		′es 2□N		Of Location (6	Very set a seed \$1, on		18
=	after Direct	Certification;	4 Homicide deter	mined	2.00. F	ouilding, etc	. (Specif	y)	eet, ractory,	, OTTICE		-	City or Tow	n, State)	iber or Hur	al Route Number,
_	To the Hospital or Attsm within 24 hours after deat To the Funeral Director: completely filled in by the		29a. Certifier 1/2 Certify	ing Phys	sician: T	o the best o	of my kno	wledge, death	occurred a	at the tim	e, date and	d place. a	and due to the	ause(s) and n	nanner as	stated.
	n 24 l n 24 l he Fu	edical	(Check only 2 Medica one)	I Examir	ier: On t	he basis of marrner sta	examina	tion and/or inv	estigation,	in my op	inion, deat	h occurre	ed at the time,	late and place	, and due t	to the cause(s)
	To the I within 2: To the I	Ž	29b. Signature and title of certif	ier /					29c.	. License	number			29d. Date sign		
	10) ///u	4						031	076	10		marco	7 91:	2006
	n		30. Name and address of perso	n who co	mpleted	cause of de	ath (Iten	n 23a) (Type,	Print)		~ 1.10		^			
, Br	9		UK. VIKCAY	Adı	t YA	100	DNO		24 S	seto	NDA	RIVE	Cum	berla	nol,	MD 21503
	Sta		31. Date filed (Month, Day, Yea		กกล	32. Registra	r's Signa	ture	medi	Q .						

DIVISION OF VITAL DECOMES, F.O. BOX 00700,
To the Hospitel or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

		For State Registrar	State o	of Marylan		artmen rtificate			and M		giene Reg. No.)	000	000	f i
		1. Decedent's Name (First, Middle, La	ist)			_				2. Date of Dea	ath Day	Yea	3. Time of D	eath
Physicia /Medica		DOROTHEA S	. N	ULLMEYE	R					MARCH	1	2006		P M
Examine		4a. Facility Name (If not institution, gir				4b. City,	Town, or	Location of	of Death		4c. C	County of De	ath	
		Brooke Grove Reh	ab. & N					dy Sp	_			Montgo		
Funeral Director		131-10-8102	Sex 1 □ M 2121 F	7. Age (In yrs. 90	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da Feb • 1	h y, Year) .7 19	(irthpiace (State or F Country) New York	Foreign
pu s	-	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City	Limits
sho	5	Md. Montq	omery		Brooke								1 ☐ Yes 2	
the N	ect	10e. Street and Number				10f. Zip	Code				10a. Citiza	en of What (Country?	
with e or	급	19221 Mt. Aire	v Road			102.0	0000	2083	3			ted St		
eath	Funeral Director	11. Marital Status		edent Ever in U	.S. 13.	Was Deced	lent of His			ecify Yes or No Rican, etc.)			nerican Indian,	
fter d	듄	1 ☐ Never Married 2 ☐ Married	Armed F	orces? 2 ∑ ⊀No						Rican, etc.)		Black, Wi		
urs a	2	3 Widowed 4 ☐ Divorced	If Yes, G Year or [ive Dates:		1 ☐ Yes 2	2 (24/10)	Specify:			5	Specify:	White	
72 ho	Completed	15. Decedent's E (Specify only highest gr	ducation)	16a. Dece	dent's Usua kind of wor DO NOT us	l Occupa	tion urina mos	t of worki	ing	16b. Kind	d of Busines	s/Industry	
ithin	nple.	Elementary/Secondary (0-12)	College ((1-4or 5+)							_			
ygier ygier rer th	S	12	4		Admi	nistr							Schools	
be fill tal H odf odf	Be	17. Father's Name (First, Middle, Las William Stor	_						rs Name roth	(First, Middle,	rsch.			
Mer Marke narke	၉				105 11-18		(C4===4 =			Al Route Numbe			Zin' Codo\	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or Items 23e or 28e-f show any Injury or other traumatic event, It is Medical Example must be netitied at once.		19a. Informant's Name/Relationship William M. Nul		/ Son	3 -	-				Brookev			20833	
1 and Healt em 2		20a. Method of Disposition		20b. F	_l Place of Dispo	sition (Nan	ne of			Date			or Town, State	
age in a ge		1 ☐ Burial 2 ☐ Cremation 3		State	etropo.	,			3/3/	06	73.1.	evandi	ria, Va.	
artme artme orteni Injury	i	' 4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice		141									.1a, va.	
Depi Impo		fold all t		00470		Muri	el H.	. Bar	ber	Funeral Laytons	Home	e e Md	20882	
		23a. Part1. Enter the disease, or cor	nplications that	caused the deat	th. Do not en	ter the mod	e of dying	, such as	cardiac o	or respiratory ar	rest,	c, ma	Approximate Interval Between	
Dhysisian		snock, or near failure. List one Immediate Cause (Final	one cause on	Diration	D.								Onset and De	
Physician /Medical		disease or condition resulting in death)	a	(or as a consec	uence of):	eumo	2001 @						1 week	
Examiner	Socialistic conditions b. Advanced Semile Dementia													
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec										
nd	Examiner	that initiated events	C											
be executed sician and burial-transit														
icate b physic s the b	dicai	•	_ d											
eath certific attending p for use as i	Physician/Med	IF FEMALE:	23c If yes o	utcome of pregn	ancv						25	od Data of d	la livon	
attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 ☐ Feta nant at time of c	aldeath 3	☐Ectopic pr ☐ Other (sp					20	3d. Date of d Month	Day Yes	ar
by the a	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unkr		.ou	_ Other (sp								
that I	Y Ph	Part II. Other significant conditions	contributing to	death but not res	sulting in the u	inderlying c	ause give	n in Part I		23e. Did to	obacco us	e contribute	to the cause of dea	ath?
w requires that been signed b should be deta	d by	Acute Fernaral Ar	tery th	wombosi	s lef	+ Ex	tren	ndy		101	/es 2 □	No 3□	Probably 4 Muni	known
w req	jete		(/		24a. Was		24b. Were	autopsy findings av	ailable
nysician: The law requires that the death certificate is certificate has been signed by the attending phys I director, page 2 should be detached for use as the	Completed									autor perfo	med? 2 No	death'	o completion of cau ? es 2□ No	ISO OT
an: T tificat tor, p	Be C	25. Was case referred to medical						26. Place	of Death	Check only o				
ysici is cer direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1	Inpatient 2	ER/Outpatie	nt 3 DC	Othe	IT: 4,⊠ Ni	ursing Ho	me 5 Resid	dence 6	□Other (Sp	pecify)	
F = 70		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date	of Injury oth, Day Year)	28b. Time of Injury	if 2	8c. Injury Work	at ?		28d. Describe I	now injury	occurred		
andin ath. or: Af	atic	2 ☐ Accident investigation	on .			М		′es 2□						
after de after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	4 286 Plac	e of Injury - At h ding, etc. (Speci		reet, factory	/, office			28f. Location (S City or Tox		Number or	Ru <i>ral R</i> oute Numbe	9 <i>r</i> ,
	Medical C	29a. Certifler 1 Certifying F (Check only one) 2 Medicel Exa	miner: On the	ne best of my kno basis of examina nner stated.	owledge, deat ation and/or in	h occurred evestigation	at the tim , in my op	e, date ar inion, dea	nd place, ath occurr	and due to the red at the time,	cause(s) a date and p	and manner place, and d	as stated. ue to the cause(s)	
To th within To th	Me	29b. Signature and title of certifier				290	c. License	number			29d. Date	signed (Mo	nth, Day, Year)	
		> _ JEDLOC	ve nu			D.	3370	0			March	1,5	2006	
12		30. Name and address of person who	completed cau	use of death (Ite	m 23a) (Type,	Print)								
	Ų.	TED HOWE	-	LADE S		RD	5	MANAY	SPRI	NG, 1	MD.			
Sta Registra		31. Date filed (Month, Day, Year) MAR 0.3	673	Registrar's Sign	ature	all.								

			State of Maryland / Depa	rtment of Health and tificate of Death	d Mental Hygi	ene	13265
			Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	Physici /Medio		JOHN I. NIED		MARCH	10 2006	6:45a ^M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of De	eath	4c. County of Death	
			Chester River Hospital Center	Chestertown	(a)	Kent	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 136-18-3101 7. F 85 Yrs.	Months Days Hours M	Hrs. 8. Date of Birth (Month, Day, July 8	Year) 9. Birthp Cour 1920 New	olace (State or Foreign otry) Jersey
	pu ,		Usual Residence of Decedent				
	shov	7	10a. State 10b. County 10c. City, Town or Lo. MD Kent Chester			_ ¹	0d. Inside City Limits 1 ☐ Yes 2 🕅 No
	the M	ect	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cour	
	with Sa or	Funeral Director	202 Leeds Court	21620		J.S.A.	itty:
	death ms 2;	nera		Vas Decedent of Hispanic Origin? Yes, specify Cuban, Mexican, Pu		14. Race - Americ	
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. dother then "naturel", or tiems 23a or 28a-f show event, I're Madical Examinar must be natified at	by	1 □ Never Married 2127 Married 1127 Yes 2 □ No 1 9.4.2	Yes, specify Cuban, Mexican, Pt	uerto Hican, etc.)	Black, White, Specify: Wh	eic. nite
2-0	72 hor	Completed	15. Decedent's Education 16a. Deced	ent's Usual Occupation	working 1	6b. Kind of Business/In-	dustry
21	ithin 7	nple	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of OO NOT use retired)	C	hemica1	
2	filed w Hygier other th			hanical Engli		anufactur	er
Maryland	should be filed withir and Mental Hygiene. marked other then matic event, Ina M.	To Be	17. Father's Name (<i>First, Middle, Last)</i> Benjamin Gniedziejko		_{Name (First, Middle, M} n Zubrus	alden Sumame)	
ary	should be nd Mental marked o	-		g Address (Street and Number or	Rural Route Number,	City or Town, State, Zip	Code)
ž	and 2 alth a 127 ls		Margarette Nied (wife) 202	Leeds Court	Chestert	own, MD.	21620
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked any injury or other traumatic ev		20a. Method of Disposition 1 😾 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition cemetery, crem			0c. Location - City or To	own, State
ij	Pag ment tent: I		`4 ☐Donation 5 ☐Other (Specify) Wesley		13/06 E	Rock Hall	, MD.
Bai	permit Depar Impor any in		Ga	Name and Address of Facility Lilena Funeral	Home of	Stephen :	L Schaech
			23a. Part. Enter the disease, or complications that caused the death. Do not enter	8 West Cross	St. Gale	ena, MD.	21635 Approximate
В			shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition)		man	31,	Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in stath) a Due to (or as a consequence of):	168 WAN/C	m (ans		
	Examiner						
	D #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C				
8760,	death certificate be executed e attending physician and id for use as the burial-transit	Ical E	Sub to (or as a consequence or).				
687	ificate g phys as the	edlc	d				
Вох	h cert endin	M/U	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Felal death 3 □	Ectopic pregnancy		23d. Date of delive	*
	deat	Physiclan/Med	1 Yes 2 No	Other (specify)		Month	Day Year
0	at the d by tl etach	Phy	3 🗆 Oukilowii	dahira ayaa ayaa ia Badii	22a Did taba	acco use controute to the	an anum of doub?
	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	i by	Part II. Other significant conditions contributing to leath but not resulting in the un	deriying cause given in Part I.			ably 4 Unknown
Records,	v requ been shoul	Completed			-		•
Rec	22 2	mp			24a. Was an autopsy perform	prior to con	psy findings available mpletion of cause of
Vital		a)	25. Was case referred to edical	26 Plans of I	1 ☐ Yes 2 Death (Check only one		2 No
>	ysicie is ceri	OB	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	Othor		nce 6 Other (Specifi	v)
J of	두 두 등	n: T	27. Mann of Death 1 Natural 5 ☐ Pending (Month, Day Year) 28b. Time of Injury (Month, Day Year)	28c. Injury at Work?	28d. Describe how		
Siol	Attending Physicien: r death. ector: After this certific. by the funeral director.	catle	2 Accident investigation	M 1 Yes 2 No			
Division	in Diffe	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rura State)	I Route Number,
ш	To the Hospital within 24 hours a To the Funerel I completely filled	O	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and pla	ace, and due to the cau	use(s) and manner as si	tated.
	e Hos	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or invariant manner stated.	estigation, in my opinion, death of	ccurred at the time, dat	te and place, and due to	the cause(s)
	To th withir To th comp	ž	29b. Signature and title of Certifier	29c. License number	29	d. Date signed (Month,	Day, Year)
•	1	1	The Alum m	D3605)	7	3/15/0	6
	1941	1	30. Name and address of person and completed cause of death (Item 23a) (Type, I	•		7	
	10		Patrick Shanahan, M.D. 120 Sp. 31. Date filed (Month, Day, Year)	eer Rd. Chest	ertown,	MD. 21620	
	Sta Registr			w			
DH	MH 17 Rev 1/2	w.	MAR 1 7 2006 Meen & Joseph				
			ORIGINA	L			

06-01652 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,PII,27,pen/IE,g854,4/24/06 II State of Maryland / Department of Health and Mental Hygiene Thomas P. Nolan RJD Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) , ^{Day}2006 Year March 07, **Physician** 0934 A. M Thomas Patrick Nolan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Capitol Heights 304 70th Place If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign Country)
New York 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 🕅 M 2 🗆 F 075-62-1557 Director Dec. 6, 1961 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits ir than "natural", or itema 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Seat Pleasant Maryland Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20743 USA 304 70th Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Š 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within Depentment of Health and Mental Hygiene. Important: If Itsm 27 is marked other than 'any Injury or other traumatic event, the Muone. College (1-4or 5+) Elementary/Secondary (0-12) Census Bureau Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Patricia Skelly Michael Albert Nolan 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vienna, Va. 22182 9718 Fonda Drive, Siobhan M. Nolan Walsh-sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 3-10-06 21. Signature of Funeral Service License 22. Name and Address of Facility
Money & King Funeral Home, Inc. WIL 171 W. Maple Ave., Vienna, Va. 22180 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardiac Arrhythmia /Medical Due to (or as a consequence ol): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Seizure Disorder 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to completion of cause of death?

1

Yes 2 □ No 24a. Was an autopsy 1X Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1. Yes 2 No ဥ scene) 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No Il Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 08, 2006 mus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LI 1NG mis 111 Penn Street, Baltimore Maryland 21201 31. Date filed (Month, Day, Year) MAR 14 32 Registrar's Signature State 2006 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	arylan		irtment of H		nd Me		ene g. No. 0	6	0826	57
	Physici		1. Decedent's Name <i>(First, Middle, Last)</i> Benjamit		N	Volan				Date of Death Month eb. 2	Day	Year 006	3. Time of D	eath M
	/Medic Examin		4a. Facility Name (If not institution, give 21275 Lexwood 6. Secial Security Number 6. Se	Court Ap		2.2 A	4b. City, Town, c Lexing	ton P	ark	. Date of Birth	St.	Mar	y's	Foreign
	Funeral Director			X M 2□F	79	Yrs.	Months Days	Hours	Min. N	(Month, Day, OV. 27,	1926	Ma	place (State or I intry) ryland	Oreign
	he Maryland 18a-f show	ector		ary's	10c. City	y, Town or Lo	exingto	on Pa	rk				10d. Inside City 1 ☐ Yes 2	
	eth with ti	ral Dir	10e. Street and Number 21275 Lexwood				10f. Zip Code 206				USA			
9036	within 72 hours after deeth with the Maryland ene. than "natural", or items 23s or 28s-f show he Medical Examinat must be millified at	d by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			Vas Decedent of H i Yes, specify Cub		gin? (Specif Puerto Ric	fy Yes or No- can, etc.)	Bla	ce - Amer ck, White y: B1	•	
21215-0036	d within 72 h giene. er then "netu , the Medical	To Be Completed by Funeral Director	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5	+)	16a. Deced (Give life. L	ent's Usual Occup kind of work done OO NDT use retire	oation during most d) reman			6b. Kind of B Depar Publi	tme	nt of	
/land	uild be filed Mental Hygiarked other	To Be (17. Father's Name (First, Middle, Last) John Louis	s No	lan			_	rs Name (/	First, Middle, M e Eli	aiden Sumar zabet	,	Campbe:	11
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. mportent: If itam 27 is marked other than "natural", or items 23s or 28s-f show any injury or other treumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (7) Juanita I. Haga 20a. Method of Disposition	n/Daught	and provided the said	2197	g Address (Street 3 Clipp sition (Name of patory or other pla	er Dr		Grea		ls,	MD 206	34
Baltimo	permit. Pages Department of Importent: If it any injury or o		1 ABurial 2 Cremation 3 4 Donation 5 Other (Specify, 21. Signature of Funeral Service Licens)	Eve	ergree	n Mem. (Name and Addre	Gar. 2	Sew	ell Fu	neral	Ног	ls, MD	678
×			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused one cause on each lin	the death							red	Approximate Interval Betwee Onset and De	een_
8760,	death certificate be executed Medical Examination and physicien and dictures as the burial-transit	ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as c. Due to (or as d.			Car	ich	2				mont.	
P.O. Box 68	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pregnanc Other (specify)	у				te of deliventh	very Day Ye	ar
	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions co	0	1	ulting in the ur	nderlying cause gr	ven in Part I.			acco use con	-	the cause of dea	
of Vital Records,	The ate h page	Completed	(Diale	les				_	24a. Was ar autopsy perform 1 Yes 2	ed?	Were aut prior to co death? 1 Yes	opsy findings av ompletion of cau 2 No	allable use of
Vite Vite	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			_ Ott	200		Check only one				
ion of	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	v	ER/Outpatien 28b. Time of Injury	28c. Inju	4 🔲 1901	28	d. Describe ho			ify)	
Division	t te	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ury - At ho c. (Specify	ome, farm, stre	eet, factory, office		28	f. Location (Str City or Town		er or Rui	ral Route Numbe	37,
	To the Hospitel within 24 hours a To the Funerel Completely filled	edicai	29a. Certifier (Check only one) Certifying Phy 2 Medical Exam	rsician: To the best of iner: On the basis of and manner sta	examinal	wledge, death tion and/or inv	occurred at the treestigation, in my o	me, date and opinion, deat	d place, and h occurred	at the time, da	te and place,	and due	to the cause(s)	
)	To with com	₩.	29b. Signature and title of certifier	A far	18	MI	29c. Licens		419		d. Date signe			
	2		30. Name and address of person who c	Jarthoe	2			Ho	1600	ved,	MD 2	206	36	
100	Sta Registr	_	31. Date filed (Month, Day, Year) FFR 2 4 2006	V32. Registra	ar's Signa	bell			c					

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registra MEND#23a(a)pc	State of Ma aMD3/3/06,BM	aryland / Dep N,McCo <i>Ce</i>	artment of I			giene Reg.:No.	306	08269
	Physici /Medic		1. Decedent's Name (First, Middle, La Rachel Elizabe	> <i>i</i> /				2. Date of Dea Month Februar		, 2006	3. Time of Death 6.28P. M
	Examir		4a. Facility Name (If not institution, giv. Anne Arundel Med.	ical Cente		Anna	or Location of Dea apolis		A	County of Death nne Aru	ndel
*	Funeral Director		5. Social Security Number 6. S 577-05-7004 1	ex 7. Age ☐ M 2X F	92 Yrs.	Months Days	If Under 24 Hr Hours Mir		1913	9. Birthp Coun West	place (State or Foreign Ntry) Virginia
	Maryland I-f ahow Iind al	tor	10a. State 10b. County Maryland Anne Ai	rundel	10c. City, Town or L Annapo					1	0d. Inside City Limits 1 ☐ Yes 2X No
	h with the 23a or 28s	ai Director	10e. Street and Number 2717 Riva Road			10f. Zip Code 21	407			en of What Cour ced State	
9036	be filed within 72 hours after death with the Maryland stal Hygiene. of other than "natural", or lieme 23a or 28a-f ahow event, Tra Medical Exartirar must be rodified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		. Was Decedent of I If Yes, specify Cub		Specify Yes or No- rto Rican, etc.)		4. Race - Americ Black, White, Specify: W	
Baltimore, Maryland 21215-0036	od within 72 hogiene.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12	Jucation de <i>completed)</i> College (1-4or 5-	(Giv.	edent's Usual Occuj e kind of work done DO NOT use retire KEEDET	during most of we	orking		orivate	dustry
land	2 should be filed and Mental Hygid Is marked other surmatic event, II	To Be (17. Father's Name (First, Middle, Last) John F. Keckley			_	1	ame (First, Middle, t R. Gler		Sumame)	
, Mar,	and 2 sho alth and P 27 le me		19a. Informant's Name/Relationship (Carol J. Noll -dai		19b. Mail 4609	ing Address (Street Brandon	and Number or F Lane Bel	Rural Route Numbertsville,	r, City or Mary	Town, State, Zip Land 20	Code) 705
more	Pages 1 gient of He nt: If item		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the control o		20b. Place of Disp cemetery, cre Fort Line	ematory or other pla		Date /3006 F		ation · City or To	
Balti	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Infury or other traumatic es once.		21. Signature of Funeral Service Licentum V. /	Sagwa	et !	Panald Vonald Vonald Vonald	ess of Facility Borgward Fr Mill	dt Funera Road Belt	ıl Ho svil		yland 20705
8760,	b attending physicien and bearenaged for use as the burtat-transit	dicai Examiner	23a. Part1. Enter the disease, or compliance, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a Due to (or as a c.	consequence of):	Cerebial	шки			nt	Approximate Interval Between Onset and Death
P.O. Box 6	death certif e attending id for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	Fetal death 3	□Ectopic pregnancy	<i>y</i>		23	3d. Date of delive Month	ry Day Year
	sigr d be	Ď	Part II. Other significant conditions co	ontributing to death bu	t not resulting in the	underlying cause giv	ren in Part I.	23e. Did to			e cause of death?
Division of Vital Records,		Completed						24a. Whas a autops perform	sy med?	prior to con death?	osy findings available npletion of cause of 2 No
Ž	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2 ER/Outpatie	at 2000 Oth		ath (Check only or			
ion of	To the Hospital or Attending Physician: which 24 hours letterdar Alter this certific To the Funeral Director After this certific completely filled in by the funeral director.	ation: To	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day		of 28c. Injur	4 Nursing	Home 5 Residence 128d. Describe he			')
Divis	To the Hospital or Attending within 24 hours efter death. To the Funeral Director: After completely filled in by the fune.	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	ry - At home, farm, st (Specify)	reet, factory, office		28f. Location (S. City or Town		Number or Rural	Route Number,
	the Hospital in 24 hours e the Funeral ipletely filled	Medicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of liner: On the basis of a and manner stat	examination and/or in	th occurred at the tir nvestigation, in my o	ne, date and plac pinion, death occ	e, and due to the c urred at the time, d	ause(s) a late and p	nd manner as sta lace, and due to	ated. the cause(s)
1	within To the comple	2	29b. Signature and title of certifier	21		29c. Licens	e number			signed (Month, L	
,	6		30. Name and address of person who o				385°C			e4 1, 2	
1	Sta		31. Date filed (Month, Day, Year)		134 one	youll	Kund,	West K	NEV	MO	2077-8
	Registr	ar	MAR 03	2008	100 100						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Charles William Clark Poole Feb 23 2006 /Medical 2:55A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Solomons
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | April 7 Calvert Asbury-Solomons Health Care Center 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 ☑ M 2 ☐ F Months 99 Director 577-09-3766 1906 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Mudical Examinar must be notified at 10d, Inside City Limits Maryland Calvert Solomons 1 ☐ Yes 2X No Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 11750 Asbury Circle 20688 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after in and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ➡ No Specify: þ Specify: white 3 XWidowed 4 □ Divorced Year or Dates: WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) executive manager PEPCO 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Vernon Poole Anna Louise Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: if item 27 is n any injury or other traum once. John W. Davis III- nephew 1329 Thurston Rd. Dickerson MD 20842 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb 23 2006 20a. Method of Disposition Pages 1 ment of F 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Alexandria Virginia 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Funeral Service 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate Approxi Interval Between Onset and Death tmmediate Cause (Final Arrhythmia. **Physician** Cardiac disease or condition resulting in death) /Medical Examiner Atheroscierotic Cardiovalculas disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and I for use as the burial-trar Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy detached for Month Year Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Heart disease 1 Yes 2 No 3 Probably 4 Unknown Completed tract infection 24b. Were autopsy findings available prior to completion of cause of death? Urinary neumonia 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 214 NO Division of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₺ No ٩ 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Diractor: the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ana. D 50653 23-2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN . C . SURANN 5851-Deale Church ton Road 20751 Deale MD 31. Date filed (Month, Day, Year) 32. Registrate Signature State 8 2006 Registrar

	1 - For State Registrar	State of Marylar	•	nent of He cate of D		ientai Hy	giene Reg: No.	08271
	Decedent's Name (First, Middle, Lass)	t)				2. Date of De	aath	3. Time of Death
Physician /Medical		Phoebu		· · · · · · · · · · · · · · · · · · ·		MARC	1) 02	200 9 50 PM
Examiner		street and number)	4b.	City, Town, or L	ocation of Death		4c. County o	
	Manokin Manor Nu 5. Social Security Number 6. Se		P last hirthday) If U	rincess	Anne If Under 24 Hrs.	8. Date of Bi	Somer	
Funeral Director	218-14-4348	M 20 F 85		nths Days	Hours Min.	8. Date of Bi (Month, Di 01/26/		9. Birthplace (State or Foreign Country) Maryland
yland	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Location	1				10d. Inside City Limits
e Mai	MD Somers	et I	rincess A	Anne				1 Yes 2 □ No
1	10e. Street and Number		10	f. Zip Code			10g. Citizen of Wi	hat Country?
Z ath w	11974 Edgehill Te			2185			USA	Annuine Indian
Baltimord, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If term 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Exart or must be facility at once.	11. Marital Status Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in to Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		es 200 No	panic Origin? (Spi , Mexican, Puerto Specify:	Pican, etc.)	Black Specify:	- American Indian, , White, etc. White
2 hours	15. Decedent's Ed	ucation	16a. Decedent's	Usual Occupat	ion	·	16b. Kind of Bus	
21215-0036 21215-0036 ad within 72 hours at ygiene. "natural", or in the wedleal Exern to the wood of	(Specify only highest gra	College (1-4or 5+)	life. DO No	OT use retired)	iring most of work	ing		
212 Significant Page 1	12	none	Dieti				State Ho	
be fill doth	17. Father's Name (First, Middle, Last)						, Maiden Sumame)
Maryland 2121 2 should be filed within a nad Mental Hygiene. The marked other than "traumatic event, the Maryland To Be Compile	Jess M. Phoebus	Suna (Defeat)	10h Mailine Ad	dense (Ctroot or	Lois Na		WSON er, City or Town, S	State Zie Codel
Maryland of 2 should be file th and Mental Hy to 1s marked oth traumatic event	Peggy Tarr/Siste						MD 21826	
1 and Health tem 27 other to	20a. Method of Disposition	20b.	Place of Disposition cemetery, crematory			Date		City or Town, State
mor Pages nent of int: If It	1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal Irom State			1	06/2006	Princess	s Anne, MD
Baltimore Department of He Important: If Iter Important: If Iter Important: If Iter	21. Signature of Puneral Service Light	Ş00	22. Nan H in r	ne and Address nan Fun	of Facility eral Home	e, 116	73 Somer	
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	M0029	th. Do not enter the	mode of dying,	nne, Mar such as cardiac	y Land 2 or respiratory a	.1853 irrest,	Approximate Interval Between
Physician	Immediate Cause (Final	a. CLOSTRIA						Onset and Death
/Medical	disease or condition resulting in death)	a. Due to (or as a conse		.,				700013
Examiner	Someontially list conditions	b						
P is	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):					
o, executed in and inal-transit	that initiated events resulting in death) Last	c. Due to (or as a conse	Tuence of):					
60, be ex ician buria		240 10 (0) 20 2 00/100	4401100 017.					
68760, firste be executed applysician and the burial-transit and the burial-transit editorial Examination		d						
Box sath certification of the use a for use a		23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 □Ecto	pic pregnancy er (specify)			23d. Date Mont	of delivery th Day Year
P.(ontributing to death but not re	sulting in the underly	ving cause giver	n in Part I.	23e. Did	tobacco use contrit	bute to the cause of death?
cords, P.O. requires that the de been signed by the should be detached	ATRIAL FIR		,			10	Yes 2□No 3	3 Probably 4 Dunknown
II Records, The law requires I age has been signe	CEREBRO V		LIPENT			24a. Was	an 24b. W	ere autopsy findings available for to completion of cause of
Vital Recipion: The law sician: The law scentificate has recipion, page 2						auto perf 1 Yes	ormed? de	ior to completion of cause of eath? □ Yes 2□ No
/ital					26. Place of Deat			
of Vi	examiner?	Hospital: 1 Inpatient 2	ER/Outpatient 3	□ DOA Other	4 Nursing Ho	me 5 Res	idence 6 Other	r (Specify)
ng Pt fler th		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work?	at ?	28d. Describe	how injury occurre	d
SiO sendi eath. or: A the fu	2 Accident investigation		N		es 2 No			
Division C Division C tel or Attending P s after death. at Director: After t ed in by the funera	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, street, fa ify)	actory, office		28f. Location City or To	(Street and Number wn, State)	r or Rural Route Number,
Division of Vital To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director. A		ysician: To the best of my kn niner: On the basis of examin and manner stated.						
o the lithin 2 or the comple	29b. Signature and title of eartifier	and mailler stated.		29c. License	number		29d. Date signed	(Month, Day, Year)
P. N. P. S.	5	MA		100	062916		MARCH	03, 2006
	30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, Print)					
	SVETERNA GUTTENA	el ma 1	115 Som	ed 110:	sion sui	7 8	SAUSHUR	47 040 2180 cg
State	31. Date filed (Month, Day, Year)	32. Registrar's Sign		li e				
Registrar	■ MΩKH /	/ 112 10 VE 20 10 0 0 0 0	Ta Am	10 a 10 a 10 a 10 a 10 a 10 a 10 a 10 a				

1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Α. Praley, Sr. February 25, 2006 7:30 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Heritage Harbor Nursing Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct. 25, 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2 ☐ F Yrs. 80 MD Director 220-16-4727 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examirer nuck be notilled at 1 Yes 2X No Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8012 Elvaton Road 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: Korea 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: þ Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Anne Arundel County 4 Chief of Police 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental H ie marked of permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked t eny injury or other traumatic eve Augusta Wimmer Frank Praley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Praley/Wife 8012 Elvaton Road, Glen Burnie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 28 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Cemetery Glen Burnie, MD 2006 21. Signature of Funeral Pervice Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 ada. Parti. Enter the disease, or complications that reused the death. shock, or heart failure. List pny one cause on each line. Approximate Interval Between Onset and Death po not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of) Examiner Due to (or as the attending physicien and hed for use as the burial-transit Velunon1 a (or as a consequence of): andiovascular Disease Physician/Medical IF FFMALE: dutcome of pregnancy If yes, outcom 1 Live birth 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 3 Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No this certificate To the Hospital or Attending Physician: 25. Was case reterred to medicat examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Cther: ဥ 1 Tes 2[2 ER/Outpatient 3 DOA ursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After Natural' 5 Pending death. 1 Yes 2 No investigation 2 Accident in by the within 24 hours after death To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 (Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) D00586 leted cause of death (Item 23a) (Type, Print) 30. Name and address of person Richard Akøtø, M.D., 344 W. University Blvd, #326, Silver Spring, MD 20901 32/Registrar's Signature 31. Date filed (Month, Day, Year) State

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

2006

State of Maryland / Department of Health and Mental Hygiene [] [For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year FEBRUARY 27, 2006 **Physician** LILLIAN JUANITA DYSON PAYNE 9:16 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FORT WASHINGTON HOSPITAL FORT WASHINGTON PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 □ F Yrs. 232-32-3859 76 MAY 23. 1929 WEST VIRGINIA Director Usuaf Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State ir then "neturel", or Items 23e or 28e-f shov the Medical Examiner must be nutified at 1 ☐ Yes 2 X No Director MARYLAND PRINCE GEORGES CLINTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2310 NORRIS WAY 20735 UNITED STATES within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XX No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 YEARS LICENSED PRACTICAL NURSE FEDERAL GOVERNMENT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental LILLIAN L. JOYCE DYSON BRUCE ROBERT EUGENE DYSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 08 of Health a: BRIGITTE PAYNE HAWKINS/DAUGHTER 2309 JOSEPH DRIVE, CLINTON, MARYLAND Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Magazial 2 □ Cremation 3 □ Removal from State t. Pages 1 artment of I ō permit. Pagi Department: Importent: If eny injury o MARYLAND VETERANS CEM.MARCH 7, 2006 CHELTENHAM, MARYLAND □Donation 5 □ Other (Specify) 21. See at re of Funeral & rvice Licenses 22. Name and Address of Eachily THORNION FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 LADIA C. THORNTON JOHNSON MODS83 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of): Examiner YPERTENSIVE CARDIOVASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). death certificate be executed physician and is the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical as attending esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔂 No Year ŏ Month 4☐Pregnant at time of death 5 Other (specify) o. the detached 9□ Unknown 9 Unknown à signed I 23e. Did tobacco use contribute to the cause of death? Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ò 1 Yes 2 No 3 Probably 4 Unknown EREBROVASCUL AR ACCIDENT Completed peen 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No After this funeral of 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident To the Funeral Director: completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide hours after To the Hospitel or within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 06 101 00209 30. Name and address of person who completed cause of death (Item 23a) Pype, Print) WASHINGTON MD 20144 RD #309 LIVINGSTON M.D VICTOR 11701 31. Date filed (Month, Day, Year) MAR 0 32. Registrar's Signature

State

Registrar

3 2006

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 4. 2006 6:45 LOUIS CARL PHILLIPS р /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Civista Medical Center LaPlata, MD Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Funeral Birthplace (State or Foreign Country) 1X□M4 2□ F Director 86 578-12-0611 DEC.19,1919 NORTH CAROLIN Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. Count 10d. Inside City Limits of Health and Mental Hygiene.
item 27 Is marked other then "naturel", or Itams 23a or 28e-1 ehov other treumatic event, The Medical Examinant must be notified at 1 ☐ Yes 🏋 No **Funeral Director** MARYLAND CHARLES WALDORF 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 5022 DORCHESTER CIRCLE 20603 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after X ⊠Yes 2 □ No
The Yes, Give Year or Dates: 1942-1945 1 □ Yes 2♥ Year or Dates: 1942-1945 1 □ Yes 1 Never Married Married Specify: Be Completed by Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 INVESTIGATOR IRS-US GOVERNMENT Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should ba fill trant of Health and Mental Heent: If item 27 is marked oth jury or other treumatic even ည LONNIE JACKSON PHILLIPS ETHEL LEEDRAPER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARTHA C. PHILLIPS-WIFE 5022 DORCHESTER CIRCLE, WALDORF, MD 20603 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XX urial 2 Cremation 3 Removal from State permit. Page Department o Importent: If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND VETERANS CEM. 3-10-06 CHELTENHAM, MD M00479 21. Signature of Funeral Service Licensee 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. 23a. Part1. Enter the disease, or complications that agused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Chanic Branchitis Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy õ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ounknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an autopsy performed: 2 No 1 Yes or Attending Physicien: Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient 1 Yes 2 ▼No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending s after death. investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature aportitle of certifier 29c. License number 29d, Date signed (Month, Day, Year) D-0058095 2006. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tonya L Hardy, 11345 Pembrooke Squ., Ste. 104, Waldorf, MD 20603 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 6 Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death February 27, 2006 **Physician** 11:50P_M Francisca /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Silver Spring Millienium Nursing and Rehab | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Sept. | 25, 1905 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 F Nicaragua 100 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State in than "natural", or Itams 23a or 28a-f show the Medical Examinar must be notified at 1 TYes 2 □ No Director 01ney Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Nicaragua 20832 3816 Roseneath Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1ऍYes 2□ No Specify: Nicaraguan White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clothing Seamstress 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be i. Pages 1 and 2 should be f tment of Health and Mental I tant: If Item 27 is marked o Maria Rios Francisco Valle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3816 Roseneath St. Olney, MD 20832 Lillyan Victoria Garcia - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Norbeck Memorial Gards. 03/03/06 Olney, Maryland 22. Name and Address of Facility Hines - Rinaldi Funeral Home, Inc. 21. Signature of unera Service Licenses 11800 New Hampshire Ave. Silver Spring, MD 20904 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) FAILURE TO THRIVE Physician /Medical Due to (or as a consequence of): Examiner ADVANCED ALZHEIMER'S Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit CVA Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 s performed? Yes 2 No 1 Yes After this certification funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: ို 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 2 Accident s after dec. 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, larm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 1, 2006 24658 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

John McNeil, MD

31. Date liled (Month Day, Year) WAR 0

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

32 Registrar's Signature

2006

2041 Georgia Ave NW Washington, DC 20060

	•	For State Registrer	State	of Marylar		artment of H		d Mental H	ygiene Reg. No	UUU	082	77
1 82		Decedent's Name (First, Middle, L.	.ast)					2. Date of D	Death		3. Time	of Death
Physicia /Medic		Elizabeth Ramsbu	ro Richa	ards				March	10.		4:10	РМ
Examine		4a. Facility Name (If not institution, g	ive street and n	umber)		4b. City, Town, o	r Location of D			c. County of De		
	-	629 Biggs Avenue				Frederic	ck		Fr	ederic	k	
Funeral		,	Sex 1 □ M 2 🗓 F	7. Age (In yrs.		If Under 1 Year Months Days		Hrs. 8. Date of B	Birth Day, Year	9. 8	irthplace (State Country)	or Foreign
Director		213-18-1914	I NI SEMI	88	Yrs.					1917 Ma	ryland	
and		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	ecation					10d. Inside	City Limits
Mary 1 aho	ō	Maryland Frederi	o lz	Frod	lerick						1 ∑ Ye	s 2 No
the route	Director	10e. Street and Number	CK	ried	IELICK	10f. Zip Code			10g. C	itizen of What	Country?	
3a o		629 Biggs Avenue				21702			USA			
deeth	Funeral	11. Marital Status	12. Was De	cedent Ever in U	I.S. 13.		lispanic Origin	? (Specify Yes or Nuerto Rican, etc.)			nerican Indian,	
27215-UU36 4 within 72 hours after deeth with the Maryland jiene. 1 then "neturel", or iteme 23a or 28e-1 ehow the Medical Examiner must be routlised at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	Armed F 1 Tes If Yes, G Year or	2∭XNo Sive	1	if Yes, specify Cub 1 □ Yes 2 🏡 No		uerto Rican, etc.)		Specify: W	nite, etc. hite	
"natural", or	ted	15. Decedent's	Education		16a. Dece	dent's Usual Occup	pation		16b. H	Kind of Busines		
within 72 ene. than "nat	Completed	(Specify only highest g Elementary/Secondary (0-12)		(1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of d)	working			,	
d with	E	12	College	(1-401.54)	homem	aker			hon	ne		
be filed tal Hyging dother event, in	Be C	17. Father's Name (First, Middle, Las	st)				18. Mother's	Name (First, Midd	le, Maidei	n Sumame)		
	10	Archibald Everet	t Fisher	r			Vallie	E. Ramsl	burg			
ire, Maryle s 1 and 2 should f Heelth and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street	and Number o	r Rural Route Num	ber, City	or Town, State	, Zip Code)	
2 9 E E		Thomas C. Kline,	son				nue, Fr	ederick,		21702		
Pages 1 Performant: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from		Place of Dispo cemetery, crei	sition (Name of matory or other pla	ce)	Date	20c. L	ocation - City	or Town, State	
Pag ment tant: jury		4 □ Donation 5 □ Other (Spec	cify)			g Cremato			Smi	ithsbur	g, Mary	land
Baltimore, permit. Pages 1 at Department of Hee Important: if item any injury or othe		21. Signature of Funeral Service Lic	ensee	м00				Keeney ar Street, E				
		23a. Part1. Enter the disease, or co shock or leart failure. List on	mplications that	caused the deal							Approxima Interval Be	
Physician		Immediate Cause (Final disease or condition	ly one cause on	STA	00	1.5H	Places	ressive	d	000	Onset and	J Death
/ /Medical		resulting in death)	a Due to	o (or as a consec	quence of):	Will	1/2//		~	ver m	4	
Examiner		Sequentially list conditions	b				U					
1 p =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	o (or as a consec	quence of):							
and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C									
60, C	û	resulting in death, cast	Due to	o (or as a consec	quence of):							
के हुन हैं	dlcal	•	d									
et the death certification to the death certification to the attending to the attending to the death of the attended for use as	Me	IF FEMALE:	23c If yes o	utcome of pregn	ancv					0010		
death certifications as attending and for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 ☐ Feta gnant at time of c	al death 3	Ectopic pregnancy Other (specify)	у			23d. Date of o Month	delivery Day	Year
S the special	ysic	1 ☐ Yes 2 🔯 No 9 ☐ Unknown	9□ Unk		36411 3				•			
res thet igned by be deta	4	Part II. Other significant conditions	contributing to	death but not res	sulting in the u	nderlying cause gru	ven in Part I.	23e. Dio	i tobacco	use contribute	to the cause of	death?
ecords, P.O. law requires thet the es been signed by th 2 should be detache	d by							10	Yes 2	2□No 3□	Probably 4 🖔	JUnknown
Hecord he law requir he has been si age 2 should	Completed							24a. Wa	as an	24b. Were	autopsy finding	s available
r e e e	E O							- aut	topsy rformed?	prior t death	o completion of ?	cause of
VITAL sicien: 1 certificet rector, p	BeC	25. Was case referred to medical					26 Place of	1 ☐ Yes		0 1∐Y	es 2□No	
OT VITA Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital:	Inpatient 2] ER/Outpatier	nt 3 DOA Ott		ng Home 5 X Re		6 □Other (Si	necifu)	
O T = E		27. Manner of Death	28a. Date	e of Injury onth, Day Year)	28b. Time o			28d. Describe				
Attending Ir death.	atic	1 X Natural 5 ☐ Pending 2 ☐ Accident investigati	ion	, <i>Day</i> 7 day	injury		Yes 2 □No					
	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	200. Flac	ce of Injury - At h	юте, farm, sti	eet, factory, office			(Street a		Rural Route Nu	mber,
ital or rat Dir led in										•		
a Hoepital 24 hours a a Funeral lietely filled	edicai	29a. Certifier 1 \(\infty\) Certifying 1 (Check only one) 2 \(\begin{array}{c}\) Medical Exposes	albunet: Ou the	ne best of my kno basis of examina nner stated.	owledge, deat ation and/or in	h occurred at the till vestigation, in my o	me, date and p opinion, death o	lace, and due to the	e cause(s e, date ar	s) and manner nd place, and d	as stated. ue to the cause	(s)
To the within 2. To the Locamplet	Me	29b. Signature and title of certifier	1			29c. Licens	se number		29d. Da	ate signed (Mo	onth, Day, Year)	
		Snu	for	~	MO	D5839	1		Marc	h 13, 2	2006	
0		30. Name and address of person wh	completed cau	use of death (Ite	m 23a) (Type,							
10		Sajjad Aziz, MD,	801 To1	lhouse .	Avenue	, C-3, Fr	ederic	k, MD 21	701			
Sta	-	31. Date filed (Month, Day, Year)	32.	Registrar's Signa	ature							
Registra	ar	MAR 1 7	2006	William .	B 4	carles						

			For ⇒ State Registrar	State of	Marylar	nd / Depa <i>Cer</i>	artment <i>tificate</i>			ind M	-	giene Reg No	Anc.	08278
	Physici		Decedent's Name (First, Middle, Last, James Ja		d						2. Date of De Month 26 26 2		/ Yea	3. Time of Death 1202 A M
	/Medio Examir	_	4a. Facility Name (If not institution, give 215 Sharon Drive	street and num	ber)		4b. City, T Lusby		_ocation o	f Death		4c.	Calver	
* .	Funeral Director		5. Social Security Number 6. Se	-	'. Age (In yrs. 77	last birthday) Yrs.	If Under 1 Months	1 Year Days	Hours	Min.	8. Date of Bir (Month, Da EC 14 1	th 1928		Birthplace (State or Foreign Country) Cginia
	Maryland -f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Calvert		10c. C	ity, Town or Lo	cation							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the	i Director	10e. Street and Number 215 Sharon Drive				10f. Zip (•	izen of What ted Stat	· ·
980	d within 72 hours after death with the Maryland jiene. Ir than "natural", or itema 23a or 28e-f ehow The Medical Exam, arritual be molified at	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Gyes 2 If Yes, Give Year or Da	ces? 2 ∐ No 5/	1	Was Deceder f Yes, specif	fy Cuban	panic Orig , Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No Rican, etc.))-	14. Race - A Black, W Swhite	merican Indian, hite, etc.
21215-0036	C 2 50	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		4or 5+)	(Give	ient's Usual kind of work DO NOT use	k done du	ırina most	of workir	ng		ind of Busine	ss/Industry nstruction
and	be file ital Hyg id othe event,	e	17. Father's Name (First, Middle, Last) Albion C. Redd							r's Name ie Wal	(First, Middle ker	, Maiden	Sumame)	
Maryland	s 1 and 2 should f Health and Men item 27 is marks other traumatic		19a. Informant's Name/Relationship (7) Mary B. Redd - wife	rpe, Print)		19b. Mailir 215 Sha					/ Route Numb	er, City o	or Town, State	e, Zip Code)
Baltimore,	permit. Pages 1 and 2 s Deportment of Health an Important: if item 27 is any njury or other trau		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify,		late	Place of Dispo cemetery, crer				•	1006		_	or Town, State 7irginia
Balti	permit. Departm Imports any inju		21. Signature of Funeral Service Licens	99		12020					isch Fune Republi			
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. LU Due to (c	ch line.	esion quence of):		of dying	, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death Mon 7h S
.O. Box 68760,	The law requires that the death certificate be executed site has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d 23c. If yes, outc	nth 2 ☐ Fet unt at time of	nancy al death 3	Ectopic pre						23d. Date of Month	delivery Day Year
<u>α</u>	quires that the signed by all be detacted	۵	Part II. Other significant conditions co	ntributing to de	ath but not re	sulting in the u	nderlying ca	iuse give	n in Part I.			obacco Yes 2		e to the cause of death?
of Vital Records,		Completed									24a. Was auto perfo 1 \(\text{Yes} \)		Drior	autopsy findings available to completion of cause of 1? Yes 2 \(\square\) No
Zi:	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		7500		Othe	F.		(Check only		a Elou (a	
Division of	ding Afte fune	Certification: To	1 Yes 75 No 27. Manner of Death Shatural 5 Pending Accident investigation Suicide 6 Could not be	28a. Date o (Month	f Injury n, Day Year)	ER/Outpatier 28b. Time o Injury	f 28	Bc. Injury Work 1 Y	4 🗆 190	No 2	ne 5 Resi 28d. Describe	how inju	ry occurred	
Divi	tal or Attences after death	Certifi	4 Homicide determined	28e. Place buildin	of Injury - At I g, etc. <i>(Sp</i> ec	nome, farm, str lify)	eet, factory,	, office		2	City or To	Street ar wn, State	nd Number or e)	Rural Route Number,
	To the Hospital or Attent within 24 hours after dealt To the Funerat Director: completely filled in by the	edical (29a. Certifier Check only one) 2 Medical Exam	sician: To the iner: On the ba and mann	sis of examin	nowledge, deat lation and/or in	h occurred a vestigation,	at the time in my op	e, date an inion, dea	d place, a th occurre	and due to the ed at the time,	cause(s date an) and manner d place, and	r as stated. due to the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier	w			29c.	License	number	061		29d. Da Rb	ite signed (M	anth. Day, Year)
ا ا	20+1		30. Name and address of person who o	ompleted cause	of death (Ite	em 23a) (Type,	Print)	Fo	eder	rck	MI)	206	78
	Sta Regist	ate rar	30. Name and address of person who of the person who do not be seen as a seen and address of person who do not be seen as a se	8 2006	egistra & Sign	nature	Lon	Mes.						

			1 - For State Registrar	State of	Marylan	d / Depa <i>Cer</i>	artmen rtificat	t of H e of L	lealth a Death	and M		giene () () 6	08279	
	Physici	an	Decedent's Name (First, Middle	_							2. Date of De Month	ath Day	Year	3. Time of Death	
	/Medic	al	RAY	Ron			45 035	T		(D)	FEBUR	AM 24,			1
	Examin	er	4a. Facifity Name (If not institution BALLIMORE WAS		per)	Take	-	en	Bur		=	4c. Count	OF Death	Apundel	1
	Funeral		5. Social Security Number	U. Spex	. Age (In yrs.	last birthday)	ff Under Months		If Under Hours		8. Date of Bir (Month, Da	th v Year)	9. Birth	place (State or Foreig	חו
	Director		219-28-8351	1 XM 2 ☐ F	73	Yrs.	Months	Days	Hours	Min.	Sep. 1	1, 1932	200	MD	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation		-					10d. fnside City Limits	
	Mary -feb	tor	MD Ann	e Arundel				Arn	old					1 ☐ Yes 2 , ☐ No	5
	death with the Maryland me 23a or 28e-f ehow r must be notified at	Funeral Director	10e. Street and Number				10f. Zip	Code				10g. Citizen of	What Cou	intry?	
١	ath w	rai	356 Long Mead					210				1	USA		
The same	ter de	une	11. Marital Status 1 ☐ Never Married 2 ☑ Marr	12. Was Deced Armed Ford ied 1 ☐ Yes 2	es?	.S. 13. \	was Deced	dent of Hi cify Cuba	ispanic Ori in, Mexicar	gin? (Spe n, Puerto l	ecify Yes or No Rican, etc.)	Bla	ck, White	can Indian, , etc.	
036	al', or	b	3 Widowed 4 Divorced	If Yes, Give Year or Dat	es:		1 🗌 Yes	2፟X No	Specify:			Specil	y:	White	
₽ G	72 ho 'natur	Completed	15. Deceden (Specify only highes	t's Education		16a. Deced	kind of wo	rk done d	during mos	t of workii	ng	16b. Kind of B	usiness/li	ndustry	
₹ 5	within ane. then '	mp	Efementary/Secondary (0-12)	Colfege (1-4	for 5+)	life. L	DO NOT us Cu	se retired Istod				Anne Ar	runde	l Police	
, 2 2	other ent,	Be Co	8 17. Father's Name (First, Middle,	Last)		<u> </u>			18. Mothe	er's Name	(First, Middle	, Maiden Sumai	ne)		
lan	uld be Menta Irked Itlc ev	ToB	John Adam Reu	sing					Mil	dred	S. Go	uker			
San	12 sho		19a. Informant's Name/Relations Margaret r. R				-				Arnold	er, City or Town	State, Zi	o Code)	
() e	1 and Health		20a. Method of Disposition	eusing/wii	20b. P	lace of Dispo	sition (Nar	ne of			ate	20c. Location		own, State	_
$\mathcal{E}\mathcal{US}_{\mathcal{K}}$ imore, Ma	Pages lent of nt: If if		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			emetery, cien en Have			ry	Feb.	27 , 006	Glen E	Burni	e, MD	
REuSing , RAY Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural", or iteme 23a or 28e-1 show eny injury or other traumatic event, the Medical Examiner must be notified at once.		21 Signature of Funeral Service	Licenson	\sim	B	arran	d Addra				erna Par	k Fu	neral Home D 21146)
	au= • a		23. Parl1. Enter the disease, or	complications that can	used the deat								K, M	D Z1146 Approximate	_
	Physician		shock or heart failure. List Immediate Cause (Final	only one cause on ear	ch line.									Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	aDue to (o	r as a conseq	uence of):		0	43110	, ,					
	Examiner	L	Sequentially list conditions,	b	NESP	rRAS	DRY		Test	ilus	CAJ.				
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	O) of to each	ras a conseq.	CONER	5000	//	TRS						
ó	executing and rial-tra		that initiated events resulting in death) Last	c Due to (o	r as a conseq										
8760,	cate be executed physician and the burial-transit	dicai		d											
9	entifica ding pl	Med	IF FEMALE:	22a Huan auto											
Box	that the death certific ed by the attending p detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		ome or pregna th 2 ∏ Feta nt at time of d	fdeath 3 ☐	Ectopic pr					1	ite of deliv onth	ery Day Year	
o.	t the d by the ached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknov			3 0 1170 (0)2	,,							
Division of Vital Records, P.O.	Physician: The law requires that the death certific this certificate has been signed by the attending praid director, paga 2 should be detached for use as:	by P	Part II. Other significant condition	ons contributing to dea	th but not res	ulting in the u	nderlying c	ause give	en in Part I					the cause of death?	
ord	requir seen s hould	eted									1	Yes 2□No	3 □ Pro	bably 4 TUnknowi	1
Rec	nelaw hast ga 2 s	Completed									24a. Was auto		Were auto prior to co death?	opsy findings available ompletion of cause of	e
ta_	an: The	Be Co	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes	26 No	1 🗌 Yes	2 1 No	-
Ž	ysicia iis cer direct	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	patient 2	ER/Outpatien	nt 3 🗆 DC	Oth	0.0			dence 6 □Oti	ner (Speci	fy)	
0	ing Pt Viter th		27. Manner of Death 1. ☑ Natural 5 ☐ Pendin	28a. Date of (Month	Injury , <i>Day Year)</i>	28b. Time of Injury		28c. Injun Work			28d. Describe	how injury occur	red		
isio	Attending in death.	icati	2 Accident investig 3 Suicide 6 Could	not be	of Injury - At ho	ome farm etr	M eet facton		Yes 2□		28f Location /	Street and Num	her or Rur	al Route Number,	
Div	alor A satter il Dire id in by	Certification;	4 Homicide determ		g, etc. (Specif		eet, lactor	y, onlog			City or To		JOI 01 1101	arriodio reditiber,	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certilicate ha completely filled in by the funeral director, paga	edicai (29a. Certifier Certifyir	g Physician: To the be Examiner: On the bas and manne	sis of examina	wledge, death tion and/or in	h occurred vestigation	at the tim	ne, date ar pinion, dea	nd place, a	and due to the ed at the time,	cause(s) and m date and place,	anner as : and due !	stated. to the cause(s)	
	To the within 2 To the comple	Med	29b. Signature and title of certifie		, stateu.		290	c. License	e number			29d. Date signe	ed (Month,	Day, Year)	
			1 / Ser	lu				10	033	70	3	FORUN	1714	24,2006	
-			30. Name and address of person		of death (Item	1 23a) (Type,	Print)		_ //1 4.4		61			24, 2006 J	
	Sta		31. Date filed (Month, Day, Year)	JASUNGIL 32.80	ر سر (gistrar's Signa		IN	Co	WIUN	16	10243	une	M	<u></u>	_
- 1	Registr		MAR 0 2	/82		K A	malh								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Day 11:04 PM **Physician** 27 AD4 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Clinton Bradford Oaks Nursing Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 18 Oct. 14, Birthptace (State or Foreign Country) 7. Age (In yrs. last birthday) Days **Funeral** 1 □ M 2 🔀 F South Carol. 87 243-36-1577 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County Items 23e or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Prince Georges Clinton MD Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 20735 5611 Sanjuan Dr. death v Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2X No Specify: Specify: Black þ 3 XWidowed 4 ☐ Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) other than Elementary/Secondary (0-12) Self Employed Beautician 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If tiem 27 is marked oth any july or other traumatic event 2008. Be Loma Mackey Frank White 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5611 Sanjuan Dr. Clinton, MD 20735 19a. Informant's Name/Relationship (Type, Print) Crawford Mickles/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Suitland, MD Washington Nat'1 3/7/06 22. Name and Address of Facility
Adams Funeral Home, PA 20605 Aquasco Rd. 21. Signature of Faneral Service Licen Aquasco, MD 20608 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ARTEVIS SCLETS TIC Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit iding physician and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 1 ☐ Yes 2 No Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one Be examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P ġ this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No М death. Director: Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide hours after within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1701 Livingsta Rond, Fort wastington 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1. TAnnway

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

MAR 0 3 2006

32. Signature

			1 - State Registrar		Department of Health and I Certificate of Death		og. No.2 0 0 6	08281
10 19	Dhysisi	20	Decedent's Name (First, Middle, Last)			2. Date of Deat Month	h Day ¬Year	3. Time of Death
	Physicia /Medic		JAMES E. ROGERS			03	09 2006	19:40 M
	Examin	er	4a. Facility Name (If not institution, give street and nur	mber)	4b. City, Town, or Location of Deat	h	4c. County of Death	
	·	ggi-dk"	5. Social Security Number 6. Sex	OPTIME 7. Age (In yrs. last birti	hday) If Under 1 Year If Under 24 Hrs	8. Date of Birth	9 Birthol	Tace (State or Foreign
46.	Funeral Director		235-52-5102 1 [™] M 2□F		rrs. Months Days Hours Min.		Year) Coun	eville, WV
` '₹.	%		Usual Residence of Decedent				,,1933 11145	eville, wv
	how		10a. State 10b. County	10c. City, Town	or Location		10	0d. Inside City Limits
	Ba-fs	cto	WV Mineral	Keyse	er			1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number		10f. Zip Code	1	0g. Citizen of What Coun	itry?
	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show Jigel Examinational be rediffed at	ral	Rt. 1, Box 111-A Knob		26726		USA	
	er de Itam	Funeral	11. Marital Status 12. Was Dece Armed Fo 1 ☐ Never Married 2 ☒ Married 1 ☒ Yes		13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	14. Race - America Black, White,	
36	rs aft	by F	If Vac Ci		1 ☐ Yes 2 🖾 No Specify:		Specify: Whi	te
215-003	2 hou ature	ted	15. Decedent's Education	16a.	Decedent's Usual Occupation		16b. Kind of Business/Inc	
212	_ × N	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1	-	(Give kind of work done during most of worlife. DO NOT use retired)	rking		
7	filed within Hygiene. rther than "	ПO	12		Master Gunnery Sgt.		U.S. Marine	e Corps
2	m ~ 0 €	Be	17. Father's Name (First, Middle, Last)		18. Mother's Nar	me (First, Middle, M	Maiden Sumame)	
<u>X</u> a	ould be I Mental I warked o	ဥ	Holmes Rogers		Nannie			
Maryland	12 sh and 1 s m		19a. Informant's Name/Relationship (Type, Print)	- 1	Mailing Address (Street and Number or Ru			Code)
	1 and Healt em 2 ther 1		Marilyn G. Rogers/ Wife 20a. Method of Disposition	20b. Place of	Disposition (Name of	eyser, WV	26726 20c. Location - City or To	wn. State
altimore,	ages of of h		1 ☐ Burial 2 XCremation 3 ☐ Removal from	State		ch 11		
	it. Partmentant		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	The Cu	umberland Crematory 22. Name and Address of Facility Sm	2006	Cumberland,	, MD
Ba	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce.		But I And	71h	Rt. 2, Box 1-A			10
75	3		23a. Part1. Enter the disease, or complications that of	caused the death. Do n				Approximate
	Physician		shock, or heart failure. List only one cause on e	each line.	P P 12 112 11	Lani	Molada	Interval Between Onset and Death
)	Physician /Medical		disease or condition resulting in death)	(or as a consequence	1 xung with	DUALA	MUCHAS HOLD	s 4 week
3	Examiner							
14				20 5/21	nator las	Lung		
		her		Yor as a consequence of	nator of fac	lure	Metastaci.	
V		amlner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Yor as a consequence of	natory fac	lure	2	
V 0,		l Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	(or as a consequence of	or):	lur	2	
8760, <		ilcal Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	9	or):	lure	2	
x 68760, <	cate be executed physician and sthe burial-transit	edical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to	(or as a consequence of	or):	lure		
Вох	cate be executed physician and sthe burial-transit	edical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	(or as a consequence of tcome of pregnancy of the control of the c	of): 3□Ectopic pregnancy	lure	23d. Date of delive	
Вох	cate be executed physician and sthe burial-transit	edical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	(or as a consequence of tcome of pregnancy pirth 2 Fetal death nant at time of death	or):	lur	23d. Date of delive	ery
P.O. Box (cate be executed physician and sthe burial-transit	Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No Due to	(or as a consequence of tcome of pregnancy pirth 2 Fetal death nant at time of death own	of): 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive	ery Day Year
P.O. Box (cate be executed physician and sthe burial-transit	by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	(or as a consequence of tcome of pregnancy pirth 2 Fetal death nant at time of death own	of): 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ery Day Year
P.O. Box (cate be executed physician and sthe burial-transit	by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	(or as a consequence of tcome of pregnancy pirth 2 Fetal death nant at time of death own	of): 3 □Ectopic pregnancy 5 □ Other (specify)	23e. Did to	23d. Date of delive Month	ony Day Year ne cause of death? sably 4 □Unknown
P.O. Box (cate be executed physician and sthe burial-transit	by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	(or as a consequence of tcome of pregnancy pirth 2 Fetal death nant at time of death own	of): 3 □Ectopic pregnancy 5 □ Other (specify)	23e. Did tot 1 Ye 24a. Was a autops perforr	23d. Date of delive Month Dacco use contribute to the as 2 No 3 Prob n y ped?	Day Year ne cause of death? pably 4 Unknown psy findings available inpletion of cause of
P.O. Box (cate be executed physician and sthe burial-transit	Completed by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	(or as a consequence of tcome of pregnancy pirth 2 Fetal death nant at time of death own	of): 3 □Ectopic pregnancy 5 □ Other (specify)	23e. Did tot 1 Yes 24a. Was a autops perforr 1 Yes 2	23d. Date of deliver Month Dacco use contribute to the set of the	Day Year The cause of death? The cause of death? The cause of death? The cause of death?
P.O. Box (cate be executed physician and sthe burial-transit	Be Completed by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	(or as a consequence of tcome of pregnancy pirth 2 Fetal death nant at time of death own	3 DEctopic pregnancy 5 Other (specify) the underlying cause given in Part I.	23e. Did tot 1 Yes 24a. Was a autops perform 1 Yes 2 ath (Check only on	23d. Date of deliver Month Dacco use contribute to the set of the	Day Year ne cause of death? nably 4 Unknown psy findings available mpletion of cause of 2 No
P.O. Box (cate be executed physician and sthe burial-transit	To Be Completed by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	tcome of pregnancy birth 2 Fetal death nant at time of death own	3 Dectopic pregnancy 5 Other (specify) the underlying cause given in Part I. 26. Place of Destpatient 3 DOA Other: 4 Nursing H	23e. Did tot 1 Yes 24a. Was a autops perforr 1 Yes 2 ath (Check only on the character)	23d. Date of delive Month Dacco use contribute to the es 2 \(\subseteq \) No 3 \(\supseteq \) Prob or open of the condeath? 1 \(\supseteq \) Yes e)	Day Year ne cause of death? nably 4 Unknown psy findings available mpletion of cause of 2 No
P.O. Box (uing Physician: The law requires that the death certificate be executed h. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	tcome of pregnancy birth 2 Fetal death nant at time of death own	3 DEctopic pregnancy 5 Other (specify) the underlying cause given in Part I. 26. Place of Destpatient 3 DOA Other: 4 Nursing Part I.	23e. Did tot 1 Yes 24a. Was a autops perforr 1 Yes 2 ath (Check only on the character)	23d. Date of delive Month Dacco use contribute to the set of the	Day Year ne cause of death? nably 4 Unknown psy findings available mpletion of cause of 2 No
P.O. Box (uing Physician: The law requires that the death certificate be executed h. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	tcome of pregnancy birth 2 Fetal death nant at time of death own leath but not resulting in leath but not resulting in of Injury of Injury th, Day Year)	26. Place of De tpatient 3 DOA Other: 4 Nursing Highlight	23e. Did tot 1 Ye 24a. Was a autops perform 1 Yes 2 ath (Check only on Home 5 Reside	23d. Date of delive Month Dacco use contribute to the set 2 No 3 Probent Prior to condeath? 24b. Were autor prior to condeath? 1 Yes Pence 6 Other (Specify ow injury occurred	Day Year The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death?
Вох	uing Physician: The law requires that the death certificate be executed h. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	tcome of pregnancy birth 2 Fetal death nant at time of death own leath but not resulting in of Injury th, Day Year) a of Injury - At home, faring, etc. (Specify)	26. Place of De tpatient 3 DOA Other: 4 Nursing H ime of place of Descripy Aury Aury Aury Aury Aury Aury Aury Aur	23e. Did tot 1 Yes 24a. Was a autops perform 1 Yes 2 ath (Check only on dome 5 Reside 28d. Describe hotel) 28f. Location (St. City or Town	23d. Date of delive Month 23d. Date of delive Month 23d. Date of delive Month 24b. Were autor prior to cordeath? 24b. Were autor prior to cordeath? 24c. Were autor prior to cordeath? 1	Day Year The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death?
P.O. Box (uing Physician: The law requires that the death certificate be executed h. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Inpatient 2 ER/Out of Injury th, Day Year) a of Injury - At home, fairing, etc. (Specify) a best of my knowledge passis of examination and	26. Place of De tpatient 3 DOA Other: 4 Nursing Himsof Nursy M 1 Yes 2 No	23e. Did tot 1 Yes 24a. Was a autops perforr 1 Yes 2 ath (Check only on the company of the c	23d. Date of delive Month Dacco use contribute to the set of the	Day Year Day Year De cause of death? De cause of death? De cause of death? De cause of death? De cause of death? De cause of death? De cause of death? De cause of death? De cause of death? De cause of death?
P.O. Box (uing Physician: The law requires that the death certificate be executed h. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	tcome of pregnancy birth 2 Fetal death nant at time of death own leath but not resulting in fath of linjury 28b. Tird of linjury 28b. Tird of linjury 4th, Day Year)	all Ectopic pregnancy by the underlying cause given in Part I. 26. Place of De tpatient 3 DOA Other: 4 Nursing E ime of hiury M 28c. Injury at Work? 1 Yes 2 No rm, street, factory, office	23e. Did tot 1 Yes 24a. Was a autops perform 1 Yes 28th (Check only on the continuous State of the	23d. Date of delive Month Dacco use contribute to the set of the	Pay Year Day Year De cause of death? Deably 4 Unknown Desy findings available impletion of cause of 2 No No No No No No No No No No
P.O. Box (ate be executed thysician and the burial-transit	Certification: To Be Completed by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Inpatient 2 ER/Out of Injury th, Day Year) a of Injury - At home, fairing, etc. (Specify) a best of my knowledge passis of examination and	26. Place of De total at the underlying cause given in Part I. 26. Place of De total at DOA Other: 4 Nursing II Time of De Cause Injury at Work? M 1 Yes 2 No rm, street, factory, office 29c. License number	23e. Did tot 1 Ye 24a. Was a autops perform 1 Yes 2 ath (Check only on the continuous Standard Sta	23d. Date of delive Month Dacco use contribute to the set of delive Month Dacco use contribute to the set of delive Month Dacco use contribute to the set of delive Month M	Pary Pear Day Year De cause of death? Deably 4 Unknown Description of cause of 2 No Part Route Number, Day, Year)
P.O. Box (uing Physician: The law requires that the death certificate be executed h. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	toome of pregnancy pirth 2 Fetal death nant at time of death own leath but not resulting in the property of Injury 1. The proof of Injury 1. At home, failing, etc. (Specify) ended to be best of my knowledge lasis of examination and oner stated.	all Ectopic pregnancy 5 Other (specify) The underlying cause given in Part I. 26. Place of De tpatient 3 DOA Other: 4 Nursing H Time of hiury M 1 Yes 2 No rm, street, factory, office 29c. License number 29c. License number	23e. Did tot 1 Yes 24a. Was a autops perforr 1 Yes 2 ath (Check only on Home 5 Reside 28d. Describe how the caured at the time, did to the caured at the ca	23d. Date of delive Month 23d. Date of delive Month 24b. Were autor prior to correct death? 24b. Were autor prior to correct death? 1	Day Year Day Year Day Year Day Year Day Year Day Year Day Honown Day Honown Day Honown Day Honown Day Year Day, Year) Day Year
P.O. Box (uing Physician: The law requires that the death certificate be executed h. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Inpatient 2 ER/Out of Injury th, Day Year) a of Injury - At home, fairing, etc. (Specify) a best of my knowledge passis of examination and	all Ectopic pregnancy 5 Other (specify) The underlying cause given in Part I. 26. Place of De tpatient 3 DOA Other: 4 Nursing H Time of hiury M 1 Yes 2 No rm, street, factory, office 29c. License number 29c. License number	23e. Did tot 1 Yes 24a. Was a autops perforr 1 Yes 2 ath (Check only on Home 5 Reside 28d. Describe how the caured at the time, did to the caured at the ca	23d. Date of delive Month 23d. Date of delive Month 24b. Were autor prior to correct death? 24b. Were autor prior to correct death? 1	Day Year Day Year Day Year Day Year Day Year Day Year Day Honown Day Honown Day Honown Day Honown Day Year Day, Year) Day Year
P.O. Box (To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification: To Be Completed by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	toome of pregnancy pirth 2 Fetal death nant at time of death own leath but not resulting in the property of Injury 1. The proof of Injury 1. At home, failing, etc. (Specify) ended to be best of my knowledge lasis of examination and oner stated.	26. Place of De the underlying cause given in Part I. 26. Place of De thatient 3 DOA Other: 4 Nursing H Time of highly M 1 Yes 2 No rm, street, factory, office 29c. License number 29c. License number	23e. Did tot 1 Yes 24a. Was a autops perforr 1 Yes 2 ath (Check only on Home 5 Reside 28d. Describe how the caured at the time, did to the caured at the ca	23d. Date of delive Month 23d. Date of delive Month 24b. Were autor prior to correct death? 24b. Were autor prior to correct death? 1	Day Year Day Year Day Year Day Year Day Year Day Year Day Honown Day Honown Day Honown Day Honown Day Year Day, Year) Day Year

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death February 27, 2006 **Physician** Junius Benjamin Skelton 7:11p M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2 ☐ F 78 Director 30, 1927 Virginia 224-22-4653 May Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heelth and Mental Hygiane. Importent: If Item 27 is marked other than "natural", or Itams 23e or 28e-f ehow any injure or other transmatte motified at the Medical Examinar must be notified at 1 ☐ Yes XX No Director Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3902 Lantern Drive 20902 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1为 Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify:White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pharmaceutical Salesman Pharmaceutical Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Benjamin Howard Skelton Lucy Green ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris W. Skelton/ Wife 3902 Lantern Drive, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State March 2006 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory 4 □ Donation 5 □ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licensee ᢪrᡈᠬ안당^{Adgess} 안당대기가 Funeral Home Inc nemane 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician a Acute Myocardial Infarction 1 Hour /Medical Due to (or as a consequence of) Examiner Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit attending physicien end Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy deteched for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 28 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 kNo this neral Director: After th 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred 1X3Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 2 Accident 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 27, 2006 D35112 60 ID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Baker, M.D. 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 03 2005 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of Marylan		artment rtificate			nd M	, ,	iene	06	082	83.
	Physici	an	1. Decedent's Name (First, Middle, Li		a .					2. Date of Death	2 Day 2	Year	3. Time o	
	/Medic	al	Hattie	Jeanette	Sher	bert		Location of	Death	Feb. 2	7	unty of Deat		7 PM
	Examin	er	4a. Facility Name (If not institution, gi 1095 Hallowin					Fred		ck	_	alve:		
8.	Funeral Director		Social Security Number 6.	Sex 1 M 2 F 7. Age (In yrs. 7.7		If Under Months	1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birth Month, Day Mar. 13	, 1 9 2	9. Bird Co Ma	hplace (State untry) rylan (or Foreign
	pur *		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation							10d. Inside (City Limits
	Maryla	ξį	,			rinc	e Fr	eder	ick				1 🗌 Yes	2 X No
	with the	Direc	Maryland Calv 10e. Street and Number 1095 Hallowin			10f. Zip					-	of What Co	untry?	
9	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or Items 23s or 28s-1 show aumatic event. The Madical Examinar must be notified at	Funera	11. Marital Status 1 □ Never Married 2 □ XMarried	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Deced If Yes, spec			in? (Spe Puerto F	cify Yes or No- Rican, etc.)		Race - Ame Black, White	·	
9	hours tural',	ed by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	16a Dece	dent's Usua	al Occupa	tion				of Business/		
215-003	rithin 72 ne. hen *ne	Completed	(Specify only highest g	rade completed) College (1-4or 5+)	(Give	kind of wor DO NOT us .cher	rk done di se retired)	uring most	of workir		Puh1	ic S	choo1	
d 21	filed w Hygier other th	e Cor	12 17. Father's Name (First, Middle, Las	st)		Chei			's Name	(First, Middle, M				
Jan	uld be Mental rrked c	To Be	John Wesley	Stewart				F1or	enc	e Vir	gini	a K	ing	
Maryland 21		ľ	19a. Informant's Name/Relationship Oliver W. Sher							Route Number, nce Fr	-			1678
ē,	tem 27		20a. Method of Disposition		Place of Dispo			_					Town, State	3070
altimore,	0 0		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	Hemoval from State Ch	elt.			$\H{\mathbf{n}}$. $\downarrow 2$	2/28	/2006	Che1	tenha	am, MI)
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lice	Sewell	1	2. Name an 451	d Addres Dare	s of Facility	Sew ach	ell Fu Rd. P	nera rinc	1 Hore Fre	ne ed.,MI	02067
			23a. Part1. Enter the disease, or conshock, or heart failure. List on	mplications that caused the deat y one cause on each line.	th. Do not en	ter the mod	e of dying	, such as c	cardiac o	r respiratory arre	est,		Approxima Interval Be Onset and	ate stween i Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	nary	Xx	ter	7 9	3	ase				
	Examiner		Conventially list conditions	b	querice or.									
	be sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	quence of):							- 4		
,	execut n and ial-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseq	quence of):							-		
8760	cate be executed oblysician and the burial-transit	dical		d								-		
9 XO	eath certific attending pl	/Med	IF FEMALE:	23c. If yes, outcome of pregna	ancy					-	23d	Date of del	livery	
m	e death he atter ed for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		⊒Ectopic pr ⊒ Other (sp						Month	Day	Year
О. О.	res that the de signed by the a be detached f		9 ☐ Unknown Part II. Other significant conditions		sulting in the u	Inderlying c	ause give	n in Part I.		23e. Did tot	acco use	contribute to	the cause of	death?
rds,	w requires i been signe should be	ed by								1 □ Y€	s 2 🗆 N	o 3 🗆 Pr	obably	Unknown
Records,	e la has	Completed	N'							24a. Was a autops perform	ned?	death?	utopsy finding completion of	s available cause of
Vita	10	0	25. Was case referred to medical					26. Place	of Death	1 ☐ Yes 2 (Check only on	e)	1 L Yes	2 □ No	
Ž	hysici this cer al direc	To B	examiner? 1 □ Yes 2 No		ER/Outpatie			4 🗆 IVUI	sing Hor	ne 5 Reside	ence 6	Other (Spe	city)	
ouc	Attending Physician: Ir death. ector: After this certific by the funeral director,	tlon:	27. Manner of Death Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 2	28c. Injury Work 1 □ \	at ? ′es 2 □ N		28d. Describe ho	ow injury or	curred		
Division of	P di di	Certification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 280 Blood of Injury. At h	ome, farm, st					28f. Location (St City or Town		umber or Ru	ural Route Nu	mber,
	To the Hospital within 24 hours of To the Funeral completely filled	edical C		Physician: To the best of my kno aminer: On the basis of examina and manner stated.										(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifie			290	c. License	number		2	9d. Daty si	gned / ont	h, Day, Year)	
			1			-2-1	1	5/	940	7	48	4/21	06	
0	9		30. Name and a ss of person wh	11/2 1/1/2	m 23a) (Type	Printy 1		Dan	T A	Fred	000	1	M) 7	0678
	Sta	ate	David Gallatin 31. Date filed (Month, Day, Year)	M. 10 () PUS 32. Registrar's Sig	ature	100	1		CE			1.5		/ 0
	Regist		FEB 2 4 2006	Elevis G.	Coaste	1								

	1	For State Registrar	State of	Marylan		artmer rtificat			ınd M	lental Hy	giene Reg. No.	06	08284
Physicia	-	1. Decedent's Name (First, Middle,								2. Date of Dea	Day	Year	3. Time of Death
/Medica	al -	PAULINE	STURGIS	- has		45 Cibe	Tour of	Location o	4 Dooth	03	02	2006 inty of Death	02454
Examine	r	4a. Facility Name (If not institution, ATLANTIC GENERAL)					ERLIN		Death			CESTER	
Funeral				7. Age (In yrs.	last birthday)	If Unde	r 1 Year	If Under a		8. Date of Birt (Month, Da			place (State or Foreign
Director		222-05-2689	1□M 2 X F	91	Yrs.	Months	Days	Hours	Min.	APR 12	1914		YVILLE, DE
D	-	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	v. Town or Lo	ocation						1	Od. Inside City Limits
Aaryta I sho	.		SSEX		LBYVII								1 ☐ Yes 2 👿 No
the A	Director	10e. Street and Number					o Code				10g. Citizen	of What Cour	ntry?
h with	<u></u>	RT. 2 BOX 7				19	9975				UNIT	ED STA	TES
deat	Funerai	11. Marital Status	12. Was Dece Armed For	dent Ever in U	.S. 13.	Was Dece	dent of Hi	spanic Orig	gin? (Spi	ecify Yes or No Rican, etc.)	- 14. [Race - Ameni	
or its	by Fu	1 Never Married 2 Marrie	ed 1 ☐ Yes If Yes, Giv	2 X No e		1 □ Yes		Specify:				cify: BLA	
IN CILISTONOSO Illod within 72 hours after death with the Maryland Hygiene. The rhan "natural", or items 23a or 28a-f show ant, the Marical Examiner must be muitted.		3 Widowed 4 □ Divorced 15. Decedent's	Year or Da	ites:	16a. Dece	dent's Usu	al Occupa	ation			16b. Kind o	f Business/In	
in 72	piet	(Specify only highest	grade completed)	405 5 1	/Give	kind of wo	ork done a	turina most	t of work	ing			,
d with dispense	Completed	Elementary/Secondary (0-12) 8TH GRADE	College (1	-401 5+)	Γ	OMES'	CIC W	ORKE	3		HOU	SEKEEP	ING
id be file ental Hyd ked othe ic avant,	Be	17. Father's Name (First, Middle, L								(First, Middle,		name)	
Ment Ment arked	၉		LLIAMS							MAE MA			
DESILIMOTE, IMETYIELD ALLID-UUDO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic avant. The Marical Examinar must be maittied at once.	Ì	19a, Informant's Name/Relationsh		MEDITELL		•				NATE D			
t and t and Health		JAMES E. V 20a. Method of Disposition	WILLIAMS (20b. F	lace of Disp	osition (Na	me of			DALE, Di		on - City or To	
ages int of tr. if it		1 \(\overline{\chi}\) Burial 2 \(\overline{\chi}\) Cremation 4 \(\overline{\chi}\) Donation 5 \(\overline{\chi}\) Other (Sp		State	iometery, cre				EB (9,2006	CLAR	KSVILL	E. DE
DESILITION Description Pages Department of mportant: If it in it i	-	21. Signature of Puneral Service L	~	0	CEMET	. RY 2. Name a	nd Addres	s of Facilit	у	210			
Depa Depa Impo any i		Make 1	H	(-			ERAL DEL		E E 19966			
7		23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that control on each	in ad the deat							rrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	L		Ren	201	Fail	lure					Onset and Death
/Medical		resulting in death)	Due to (or as a consec									
Examiner	_	Sequentially list conditions,	5			nte	clion	1					
ed sed	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Tue to (o as a consec	juence or):								
be executed ician and burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as a consec	uence of):	<i>y</i>							
e be	cai		d										
is to	g					_							
Geath certifica e attending ph of for use as th	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, out 1□Live b	come of pregnantinth 2 ☐ Feta		⊒Ectopic p	regnancy				23d.	Date of deliv Month	ery Day Year
the deal	Sici	1 Yes 2 No 9 Unknown	4□Pregn 9□Unkno	ant at time of o	death 5	☐ Other (s	pecify)						
that the de ned by the a		Part II. Other significant condition	ns contributing to de	eath but not res	sulting in the	underlyina	cause give	en in Part I		23e. Did t	obacco use o	contribute to t	he cause of death?
0 8 <u>5</u> 8	d by	Anemia	· ·		3	, ,				10	Yes 2□N	o 3 🗆 Proi	bably 4 Unknown
	lete									24a. Was	an 2	4b. Were auto	opsy findings available
VITAI MEC sician: The law certificate has b irector, page 2 s	Completed									auto	psy ormed?/	prior to co death? 1 Yes	empletion of cause of
VITAL IICIAN: T Certificat rector, pi	0	25. Was case referred to medical						26. Place	of Deat	1 ☐ Yes h (Check only o		10165	20140
	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1	npatient 2] ER/Outpatie	nt 3□D	OA Othe	er: 4□Nu	ırsing Ho	ome 5□Resi	dence 6 🗆	Other (Speci	fy)
on of		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of (Moni	of Injury th, Day Year)	28b. Time of Injury		28c. Injun Work			28d. Describe	how injury oc	ccurred	
Attending r death. actor: Attending by the fune	cati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ation	al taina. At h		M		Yes 2□	No	201 Location /	Ctroot and N	umbor or Pur	al Route Number,
JIVISION Tor Attending after death. Director: Afte	Certification:	4 ☐ Homicide determi	nod 200. Flace	of Injury - At h ng, etc. (Speci	fy)	reet, racto	гу, опісе			City or To		umoer or nur	ar House Number,
		29a. Certifier 1 Certifying	g Physician: To the	best of my kn	owledge, dea	th occurred	at the tim	ne, date ar	nd place,	and due to the	cause(s) and	d manner as s	stated.
na Ho 1 24 h na Fur iletely	Medicai	(Check only 2 Medical E	Exeminer: On the ba	asis of examina	ation and/or it	rvestigatio	n, in my o	pinion, dea	th occur	red at the time,	date and pla	ce, and due t	o the cause(s)
To the within 2 To the complet	ž	29b. Signature and title of certifier	150	7,	_ /	29	c. Licenso	e number			29d. Date si	gned (Month,	Day, Year)
) Grego	70001	llirer	nith	W	E	106	5/2	- (13/02	1200	6
050		30. Name and address of person v	vpo completed caus	se of death (Ites	m 23a) (Type	, Print)	0-1-4	/	0-	- Borli	a NI	7210	1)
2.1 8		31. Date filed (Month, Day, Year)	Stamma:	histrar's Sinn	ature (L:	27 11	このして	way	VY	p-711	7/21	10	11
Sta Registra	-	MAR 0	3 2006	Marie .	JE A	pod	0						

Amend Item 24a State of Maryland / Department of Health and Mental Hygiene certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** FEB. 2006 RONALD 20, SMITH 1:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST. THOMAS MORE NURSING HOME HYATTSVILLE PRINCE GEORGES If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 1 XM 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Yrs. Director <u>383-46-4804</u> APRIL 3, 1947 MICHIGAN Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th end Mental Hygiene. 7 is marked othar then "natural", or frems 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No Director NONE D.C. WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1228 Funeral 18th ST. N.E. 20002 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces?

No It Yes, Give 1967—
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours efter 1 Never Married 2 → Married ຶ່1967– 19<u>69</u> Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SPECIAL SECURITY POLICE OFFICER SECURITY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f 2 HENRY SMITH PEARL UNK. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 Department of Heelth e Important: If Item 27 is any injury or ALJOYCE SMITH/WIFE 18th ST. N.E., WASHINGTON, D.C. 20002 1228 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) QUANTICO NATIONAL CEM. 3-3-2006 TRIANGLE, VA. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Artenosdorote CaudioVasulas Distate Examiner Due to (or as a consequence of) Examiner certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last end Due to (or as a consequence of): Box 68760, ettending physiclan for use es the burie Physician/Medical Due to (or as a consequence of): been signed by the e should be deteched t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 donknown 1 Tyes 2 No Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No s efter death.

I Diractor: After this of in by the funeral dire 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Matural 5 Pending 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 6 within 24 hours e To the Funerel C completely filled the Hospital 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical (Check only 29b. Signature and title of certifier 29c. License number of person who completed cause of death (Item 23a) (Type, Print) J. DEVORMB 4203 QUEENSBURY Rd Hya HSU: 11-edlo 2078/ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95

5 − () T	1530		Pie	ase Type c									9	
J			For State Registrar	State	Olivia	rytanu /	•	arimeni o <i>rtificate d</i>			Mental Hy	_	2006	08286
			Decedent's Name (First, Mide	dle, Last)					. 500		2. Date of De			3. Time of Death
и	Physic		James	Saloma							March	2.	2006 Year	4:15 a. M
ν, 3	/Medi Examii		4a. Facility Name (If not instituti		number)			4b. City, Tow	n, or Locat	ion of Death		- i	c. County of Dea	
	ZX		Washington Adv	rentist H	ospita	al		Takor	na Pai	rk		M	ontgomer	y County
	Funeral		5. Social Security Number	6. Sex		(in yrs. last i	birthday)	If Under 1 You Months Da		nder 24 Hrs.	8. Date of Bi (Month, D	rth	9. Bir	thplace (State or Foreign
	Director		003-32-9587	1 M 2 I	6:	2	Yrs.	Michinis	193 1100		08-28-	1943	Mass	sachusetts
	and *		Usual Residence of Decedent 10a. State 10b. Coun	tv		10c. City, To	own or Lo	ocation						10d. Inside City Limits
	f sho	ō	150 N	•										1 Yes 2 No
	the 1	rect	MD Monts 10e. Street and Number	gomery		Takon	na Pa	10f. Zip Cod				10a. C	itizen of What Co	ountry?
	72 hours after deeth with the Maryland neturel', or items 23a or 28a-f show dical Examiner must be ricitlified at	by Funeral Director	7124 Maple Ave	nue				209					USA	
	deeth	nera	11. Marital Status	12. Was D	ecedent Ev	er in U.S.	13.			Origin? (S	pecify Yes or No o Rican, etc.)	0-	14. Race - Ame	
9	after or its	F	1 ☐ Never Married 2 Ma	rried 10X V	d Forces? es 2 ☐ No)		1 ☐ Yes 2 🐼			o Hican, etc.)		Black, Whit	e, etc.
5-0036	irel.	d b	3 ☐ Widowed 4 ☐ Divorce	rd Year	or Dates: 1	965 – 68				cny.			Specify: W	hite
5	72 h	Completed	15. Decede (Specify only high	ent's Education lest grade complete	ed)	16	Sa. Dece (Give	dent's Usual Od kind of work do DO NOT use re	ccupation one during	most of wor	king	16b. I	Kind of Business	/Industry
2121	withir ane.	E G	Elementary/Secondary (0-12)	Colleg	e (1-4or 5+				tirea)				Financia	o 1
d 2	Hygin the mut.	ပိ	12 17. Father's Name (First, Middle	a, Last)	5+		Jons	ultant	18. M	lother's Nan	ne (First, Middle	1		11
an	d be wed c	To Be	Reina Augustus	s Saloma					Le	ona S	abonis			
Maryland	shou ind M	-	19a. Informant's Name/Relation			1	9b. Maili	ng Address (St	reet and Nu	umber or Ru	rai Route Numb	er, City	or Town, State,	Zip Code)
	elth a		Jennifer Salo	na/wife			7124	Maple .	Ave.,	Tako	ma Park	, MD	20912	
ore	of He		20a. Method of Disposition 1 Surial 2 ☐ Cremation	2 □ Bomoval te	om State	20b. Place ceme	of Dispo	osition (Name o	f place)		Date	20c. l	ocation - City or	Town, State
Ĕ	Pag ment ant: I ury o		4 □Donation 5 □Other	(Specify)	OIII State	Grace	е Ер	iscopal	Cem.	03-0	6-2006	Mou	nt Vern	on, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "neturel", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be risultied at once.		2). Signature of Funeral Service	e Licensee	Ω		H	2 Name and Adinman F	ddress of F unera	I Hom	e			
	40 E 6 0		AT USD X	KNER	×1.	M0029	5 1	1673 So	merse	t Ave	., Prin	cess	Anne,	MD 21853
			23a. Part1. Enter the disease, shock, or heart failure. Li	st only one cause	each line	he death. D	o not en	ter the mode of	dying, sucl	h as cardiad	or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			Arrho		nia						
1	Examiner			4		consequenc		10.	1.	1	1			
		-e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. 114	to (or as a	consequence	ce of):	HULOSO	(evo	ru u	useas	<u>e</u>		
	e be executed ysicien and e burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1		as	500	cated	ω ,	th c	issaw	1		
o,	exec en an rial-tr	Exa	resulting in death) Last	Due	to (or as a	consequenc	ce of):	-						
3760,	ate be nysicia he bu	cal		d										
89 3	The law requires thet the death certificate be executed as been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE:											
Вох	ath ce ttend or use	lan/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Lir		Fetel dea		⊒Ectopic pregn					23d. Date of de Month	livery Day Year
-	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		regnant at ti nknown	me of death	5[Other (specify	y)					
P.0	thet ti	Ph	Part II. Other significant condi	tions contributing	to death but	not resulting	a in the u	inderlying cause	e given in P	art I.	23e. Did	tobacco	use contribute to	o the cause of death?
of Vital Records,	w requires thet s been signed to should be deta	d by						, ,			1 🗆	Yes 2	2) No 3 □ P	robably 4 Unknown
Ö	beer shou	lete									24a. Wa	s an	24h Were a	utopsy findings available
Re	he ta e has age 2	Completed									auto perf	opsy ormed?	prior to debth?	completion of cause of
ta	en: T tificet tor, pa	0	25. Was case referred to medic	cal	-				26 F	Place of Dea	th (Check only	2 N	o 1 🗷 Yes	s 2 No
<u>></u>	Physician: The lavithis certificate has	To B	examiner? 1 XYes 2 No	Hospital: 1	☐ Inpatient	t 2 X ER/	Outpatie	nt 3 DOA	Othor				6 ☐Other (Spe	əcify)
	ding Ph After th funeral		27. Manner of Death 1 □Natural 5 □ Pend		ate of Injury Month, Day	Year) 28t	. Time o	of 28c.	Injury at Work?		28d. Describe			
Sio	Attending or death. ector: After by the fune	atle	2 Accident inves	stigation	3/2/00	6 3	001	₹ M	1 ☐ Yes	2 X No	Sul	1/20	+ assa	weted
Division	or Att	Certification:		mined 28e. P	lace of Injur uilding, etc.,	y - At home, (Specify)	farm, st	reet, factory, of	fice		28f. Location City or To	(Street a wn, Sta	and Number or R	Walle TVE
	urs a		,	des Obusidas T	'	Kend					Takon	uar	OR PC	1) '
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical		ring Physician: To al Examiner: On the and n	the best of the basis of e manner state	examination	and/or in	th occurred at the occurred at	ne time, dat my opinion,	te and place , death occu	, and due to the irred at the time	cause(, date a	s) and manner a nd place, and du	s stated. e to the cause(s)
	o the	Me	29b. Signature and title of certification					29c. Li	cense num	ber		29d. D	ate signed (Mon	th, Day, Year)
	F > F 0) Para	1 Hai	0	· N	1d	0	CME			Mar	ch 2, 20	006
			30. Name and address of person	on who completed	cause of dea	ath (Item 23	a) (Type	Print) 111	Penn	Stre	et Bali			yland 21201
-			CHROCI	+ tut	NM	d								
		ate	31. Date filed (Month, Day, Yea		2. Registrar	's Signature	1.	1						
	Regist	_	MAR	0 7 2006	July	ر معلا	S.	perte	,					
υH	MH 17 Rev 1/2	2001						•						

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	aryland / I	Departm Certific			and Me		giene Reg. No.	06	08287
			Decedent's Name (First, Middle, Last	st)						2. Date of Dea Month	Day	Year	3. Time of Death
	Physicia /Medic		Robert L.	Speak						Februar	y 28	2006	3:22P M
	Examin		4a. Facility Name (If not institution, give			4b.	City, Town, or		of Death		4c. Co	unty of Death	
			12456 Woodsboro			:	Key nder 1 Year	mar If Under:	24 Hrs	9 Date of Birt	h	Frede	
	Funeral		5. Social Security Number 6. S 178-24-8605	ex 7.Age DXM 2□F	e (In yrs. last bi 86	Yrs. Mor		Hours	Min.	8. Date of Birth (Month, Day Feb. 22	Year) 92	O Ma	place (State or Foreign intry) iryland
	Director		Usual Residence of Decedent										
	yland		10a. State 10b. County		10c. City, Tov	wn or Location							10d. Inside City Limits
	a Mar sa-f s	cto	Maryland Freder	ick			Keyma	r					1 ☐ Yes 2X No
	ith th	Dire	10e. Street and Number	D. 1		10	. Zip Code	0175	,			of What Cou	
	s 23a	ral	12456 Woodsbore		Ever in LLS	12 Was F		21757		cify Ves or No		U.S.A.	
	ltam Itam	Funeral Directo	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent I Armed Forces? 1 □ Yes 2 □		If Yes,	specify Cuba	n, Mexican	n, Puerto f	cify Yes or No- Rican, etc.)	1	Black, White	
920	urs af	by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 🗆 Y	s 2 ∑X No	Specify:			Sp	_{ecify:} Whi	te
2	72 hours after death with the Maryland Insturat', or Items 23e or 28e-1 show Jical Examination must be notified at	Completed	15. Decedent's Ed (Specify only highest gra		168	a. Decedent's	f work done o	durina mos.	t of workir	ng	16b. Kind	of Business/Ir	ndustry
2	ithin Je.	nple	Elementary/Secondary (0-12)	College (1-4or 5	i+)	`life. DO No	OT use retired)				يرمنا مام	
2	led w tygier her th		17. Father's Name (First, Middle, Last,			та	rmer	18 Mothe	ar's Name	(First, Middle,	Maiden Su	dairy mame)	
Maryland 21215-0036	ntal had ot	Be	Roy W. Speak	,						. Winpi		,	
IZ.	shout nd Me mark meti	၉	19a. Informant's Name/Relationship (Type, Print)	19	b. Mailing Add	ress (Street	and Numbe	er or Rura	l Route Numbe	er, City or To	own, State, Zi	p Code)
Ma	nd 2 alth ar 27 is		John R. Speak/ se	on	1	1063 H	aughs	Churc	h Rd	. Deto	our, M	D 2175	57
ore,	as 1 a of Hea litern		20a. Method of Disposition	Domewal from State	20b. Place cemet	of Disposition	(Name of or other place	e)	D	ate	20c. Locat	ion - City or T	own, State
Ē	Page ment ant: M		1 🔀 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Special		Creag	gerstow						erstow	vn, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-1 show amy injury or other treumetic event, It is Marical Examiner must be notified at ance.		21. Simplify of Funeral Service Licer	ISOB V	10.	22. Nan	e and Addres	ss of Facilit	Mart	zler Fu	uneral	Home	
	90 E # 9		23a. Part1. Enter the disease, or com	V. Nan						odsboro		21/98	Approximate
			shock, or heart failure. List only	one cause on each li	ne.	o not enter the	1917				i		Interval Between Anset and Death
	Priysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. 390	amo	_	111	ianco	2~ -	166_	Nm		2415
В	Examiner		ſ	Due to the as	a consequence	e orj.							
	THE P.	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence	e of):							
	cutad nd ransit	Examine	Cause. Enter Underlying Cause (Disease or injury that initiated events	c									
30,	cate be executad ohysician and the burial-transit		resulting in death) Last	Due to (or as	a consequence	e of):							
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical		d									
9 X	eath certific attending p for use as l	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy						23d	. Date of deliv	very
Вох	atten atten	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at			oic pregnancy or (specify)	·				Month	Day Year
0	at the de by the tachad	hysi	9 Unknown	9□ Unknown						-			
Б,	res that igned to be det	by P	Part II. Other significant conditions	contributing to death b	ut not resulting	in the underly	ing cause giv	en in Part I	l.	23e. Did t	-		the cause of death?
ord	v require bean sig should b									10	Yes 21	4o 3 □ Pro	bbably 4 Unknown
Records,	lawras be	Completed								24a. Was autor	nsv	prior to c	topsy lindings available completion of cause of
<u>=</u>		Con								1 ☐ Yes	2 No	death? 1 ☐ Yes	2□ No
Vital	iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth		_	(Check only o			
of	Phys this ral du	٠ <u>.</u>	1 Yes 2 No 27. Manner of Death	1 ☐ Inpation		Outpatient 3	DOA 28c. Injur	er: 4 □ Nu vat		me 5 Tesi 28d. Describe		Other <i>(Spec</i> ccurred	ify)
	ding F th: After funera	tlon	Natural 5 Pending 2 Accident investigation	(Month, Da	y Year)	Injury N		k? Yes 2. □	No				
Division	or Attending after death. Director: After in by the fune	ifica	3 ☐ Suicide 6 ☐ Could not to determined	286. Place of in	jury - At home,	farm, street, f	actory, office			28f. Location (City or To	Street and N	lumber or Ru	ral Route Number,
ă	i Ditte	Certification;	4 Hornicide	building, et	tc. (Specify)						www, Gluloy		
	To the Hospital within 24 hours a To the Funerel I completely filled	edical ((Check only 2 Medical Exa	hysician: To the best miner: On the basis o	of my knowled	lge, death occ and/or investig	irred at the tir ation, in my c	ne, date ar	nd place, ath occurr	and due to the ed at the time.	cause(s) an	d manner as ace, and due	stated. to the cause(s)
	the H the F the F nplete	Medi	one)	and manner st			29c. Licens					igned (Month	
	with Con	Σ	29b. Signature and title of certifier	16 1				_				•	., _ 4, , 541,
,	WIL		Much	Completed sources	dooth (Itam CO-	a) (Two Brits	D310	150	-		5/1/	/2006	
	6		30. Name and ddress of person who		200 Cop			Woo	odsho	ro, MD	21798	}	
	St	ate:	31. Date filed (Month, Day, Year)	32. Registi	rar's Signature					, 110	,,,		
	Regist		MAR 0 6	2006	ever L	y go	de						

			1 - For State Registrar	State of Mar		irtment of H tificate of I		lental Hygie Reg.	4000	08288	
	Physici	an	Decedent's Name (First, Middle, Las SARAH	E.	SAVAGE			2. Date of Death	Day Year	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution, give		- /	4b. City, Town, or	Location of Death		4c. County of Death		
			5. Social Security Number 6. Se	Medical L	In yrs. last birthday)	If Under 1 Year	40/48419 If Under 24 Ars.	8. Date of Birth	HICIM O Birth	place (State or Foreign	
	Funeral Director			M 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	83 Yrs.	Months Days	Hours Min.	(Month, Day, Ye MAY 10, 1	ar) Cou	ARYLAND	
1	. *		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or Lo	cation				10d, Inside City Limits	
	point. Tages faint and Mental Hygiene. Department of item 23a or 28a-1 show important: if item 27 is marked other than "natural", or itema 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	tor	MARYLAND WORCESTER BISHOPVILLE 1∑Yes 2□No								
ر د د		Funeral Director	10e. Street and Number 10f. 2			10f. Zip Code	Of. Zip Code 10g. (Citizen of What Cou	intry?	
Maryland Z1Z1S-0030 d 2 should be filed within 72 hours after death with the Maryland		era!	10618 BISHOPVILLE ROAD 11 Marital Status 12. Was Decedent Ever in U		erie II S 12 1	21813			S or No- 14. Race - American Indian,		
	al', or item	by	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Tyes 2 MNo If Yes, Give Year or Dates:	i	Yas Decement of H f Yes, specify Cuba I□ Yes 2 1 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	Rican, etc.)	Black, White		
	natur	eted	15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			ing 16b	16b. Kind of Business/Industry		
	than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		00 NOT use retired IOMEMAKER			OWN HO	ME	
	Hygic other	Be Cc	17. Father's Name (First, Middle, Last)		I	IOHEHAKEK		e (First, Middle, Maid		LILI	
	Menta Arked arked	To	GEORGE	WILLIAN				INIE	TUBB		
	th and the m 7 is m traum		19a. Informant's Name/Relationship (7 ELTON C. SAVAGE/					al Route Number, Ci VILLE, MAR		p Code) 813	
e	f Heal f Heal item 2 other		20a. Method of Disposition		20b. Place of Dispo			-	. Location - City or T		
altimo	Department of pages in its injury or once.		1 🖾 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		BISHOPVIL	*	1	/06 B	ISHOPVILL	E, MARYLAND	
ספו			21. Signature of Funeral Service Licensee 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975								
			23a. Part1. Enter the disease, or compositions shock, or heart failure. List only of	plications that caused thone cause on each line.	e death. Do not ento	er the mode of dyin	g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death	
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	0/5,5						
	Centificate be executed WE dring physicien and WE see as the burial-transit and See as the See as the burial-transit and See as the burial-transit and See a			Due to (or as a c	consequence of): ~livm ov	2,6					
7		Iner	Sequentially list conditions, if any, leading to annualities cause. Enter Underlying Cause (Disease or injury	Due to (or sac	consequence of):	, ,					
		Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence of):							
00/0		dical		. d.							
00	ing phy	Med	IF FEMALE:						F I		
cords, P.O. Box	y the atter	Physician/Me	23b. Was decedent pregnant in the past 12 menths?	pregnancy ☐Fetal death 3 ☐Ectopic pregnancy ne of death 5 ☐ Other (specify)				23d. Date of delivery Month Day Year			
		hys	9 Unknown								
	eduires ins	Ď	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknow								
l Hec	or Attending Prysician: The la fifer death. Director: After this certificate has in by the funeral director, page 2	Completed						24a. Was an autopsy performed	death?	opsy findings available ompletion of cause of 2 No	
		Be	25. Was case referred to medical examiner?	Hospital:		Oth	er	h (Check only one)			
		<u>ان</u> 1	27. Manner of Death	1 Inpatient 28a. Date of Injury (Month, Day Y		1 3LI DOA	4 🗆 Nuising He	ome 5 Residence 28d. Describe how i		ify)	
VISION		atlo	1 ∰Natural 5 ☐ Pending 2 ☐ Accident investigation	1	(ear) Injury		Yes 2 □No				
= :		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (r - At home, farm, str (Specify)	eet, factory, office		28f. Location (Stree City or Town, S	t and Number or Ruitate)	ral Route Number,	
- 3			29a. Certifier (Check only one) 29a. Certifier (Check only one) Certifying Physician: Tu the basis of my knowledge, death popured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	Prosp 24 hou Fune etely fil	dic	(Check only 2 Medical Examone)	and manner state	d.				•	to the cause(s)	
:	within 24 hours e To the Funeral is completely filled	Medical	(Check only 2 Medical Examone) 29b. Signature and title of certifier	and manner state	d.	29c. Licens			Date signed (Month		
)	within 24 hour To the Funer Completely fill	Medica	one)	and manner state	d.	29c. Licens			Date signed (Month		
) '	within 24 hour To the Funer Completely fill	Medica	one)	and manner state	d.	29c. Licens		29d.	Date signed (Month		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 1850 Dawson Earl Shaller 4c. County of Death give street and number) Fecility Name (If not institution. 4b. City, Town, or Location of Death 57 If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Yea 7. Age (In yrs. last birthday) Days 1 № M 2 🗆 F 78 213-22-6798 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d, fnside City Limits 1 ☐ Yes 2 ☐ No Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25933 Burrsville Road 21629 United States of America 12. Was Decedent Ever in U.S. Armed Forces? 1. ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 212 Married 1 ☐ Yes Ž☐ No Specify: Caucasian Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Electric stone Elementary/Secondary (0-12) College (1-4or 5+) Supervisor 11 HS Grad units manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Valentine Shaller Elizabeth Penrod 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25933 Burrsville Road, Denton, Maryland 21629 Marie Shaffer 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 13/9/2006 Denton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Denton Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, shock, or heart failure. List only one cause on each line. 13 South Second Street, Denton, 14 South Second Street, Denton, 15 South Second Street, Denton, 16 South Second Street, Denton, 17 South Second Street, Denton, 18 South Second Street, Denton, 19 South Second Street, Denton, 10 South Second Street, Denton, 11 South Second Street, Denton, 12 South Second Street, Denton, 13 South Second Street, Denton, 14 South Second Street, Denton, 15 South Second Street, Denton, 16 South Second Street, Denton, 17 South Second Street, Denton, 18 Maryland 21629 Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Invacción val Due to (or as a consequence of Dre C/ + 510 IF FEMALE: 23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 4 ☑Únknown 1 Tes 2 No 3 ☐ Probably

Physician /Medical Examiner

nding physicien and use as the burial-transit

To the Hospitel or Attending Physician: The law requires that the death certificate be executed

Director: After

within 24 hours after death.

To the Funerel Director: A filled in by the

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

þ

Be Completed

Importent: if Item 27 is marked other than any injury or other traumatic event. It is more.

Physician

/Medical

Examiner

Funeral

Director

or 28e-f show

Director

Funeral

Completed by

Be

2

with the Marylan

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

in the past 12 months? 1 Yes 2 No 9 Unknown		1 Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown		3 □Ectopic p 5 □ Other (sp		
Part ff. Dther significant co	nditions cont	ributing to death but no	t resulting in th	e underlying	ause giver	n in Part I.
Dubers	Mell	tus				
1 1 0	a la cui	· Nota	1.22	1	5.10	0000

Advanced Chronic Obstructive	lune	diserce
	· – –	

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No	1 ☐ Yes 2 ☐ No

5. Was case referred to me examiner?	edical			26. Place of Death (Check only one)							
1 ☐ Yes 2 No	Hospita	1 Inpatient	2 ER/Outpatient	3□ DOA	Other: 4 \(\sum \) Nursing Ho	me 5 Residence	6 ☐Other (Specify)				
7. Manner of Death	28a	Date of Injury	28b. Time of	28c.	Injury at	28d. Describe how in	iury occurred				

12Natural 2 ☐ Accident	5 Pending investigation	(Month, Day Year)	In i ury M	Work? 1 ☐ Yes	2 No	, , ,
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, street, facto	28f. Location (Street and Number or Rural Route Number, City or Town, State)		

2	1 ☐ Yes 2 ☑ No	Hospitaf: 1 Inpatient 2 ER	VOutpatient 3□ DOA	Other: 4 - Nursing H	ome 5 Residence 6 Other (Specify)
atlon:	27. Manner of Death 1∕S Natural 5 □ Pending 2 □ Accident investigatio	(Month, Day Year)	Bb. Time of Injury M	Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred
Certific	3 Suicide 6 Could not b		e, farm, street, factory, c	ffice	28f. Location (Street and Number or Rural Route Num City or Town, State)
edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example (Check only one)	nysician: To the best of my knowle miner: On the basis of examination and manner stated.	edge, death occurred at a and/or investigation, in	the time, date and place my opinion, death occu	and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s
Ž	29b. Signature and title of certifier		29c. l	icense number	29d. Date signed (Month, Day, Year)

29b. Signature and title of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and a second		 	_
Edston,			
I NG ton	MAX)		
1 0 0/10/11	1211		

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

		·	For State Registrar	State of Marylan	•	artment of F			Reg. No.	5 0	8290	
	Physici		1. Decedent's Name (First, Middle, Last) George Crist	Tilghman				2. Date of Dea Month March	Day	Year 6	3. Time of Death 930A M	
4.1	/Medic Examin	er	4a. Facility Name (If not institution, give st 5141 Kings Road 5. Social Security Number 6. Sex	reet and number) 7. Age (In yrs.	last birthday)	St. Led		8. Date of Birt	Calvert			
	Funeral Director		577-24-0855 Usual Residence of Decedent	M 2□F 82	Yrs.	Months Days	Hours Min.	(Month, Da		Wash	ington DC	
	the Maryla 28a-f show officed at	ector	Maryland Calver		t. Lec	_			10g. Citizen of W		1 Tyes 2 No	
	3a or		5141 Kings Road			2068	5		United			
036	e filed within 72 hours after death with the Maryland Hygiene. other then "neturel", or tiema 23e or 28e-f show vent, tte Medical Exansinat must be notified at	by Funeral Directo	11, Marital Slatus 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 Des 2 No If Yes, Give Year or Dates: WWI	? If Yes, specify Cuban, Mexican,			ecry Yes or No Rican, etc.)	14. Race Black Specify:	- America K, White, et Wh		
21215-0036	filed within 72 ho Hygiene. Ither then "netur ent, the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	16a. Dece (Give life.		pation during most of work d)	ung	16b. Kind of Bus			
	iled w Tygier ther th	Co	1.7. Father's Name (First, Middle, Last)	5+	Arc	hitect	18. Mother's Nam	e (First, Middle,			n design	
Maryland	Menta Menta arked	To Be	George Tilgham	o Drine)	10h Maili	na Address (Street		Campbe	11		Code	
g Z	hall hall		19a. Informant's Name/Relationship (Type Thomas Tilghman				ove Road			2101	- 1	
Baltimore,	ss 1 a of Hea item		20a. Method of Disposition 1 Burial 2 Fremation 3 Re 4 Donation 5 Other (Specify)	20b. I	cemetery, crei	osition (Name of matory or other pla tan Fune	°°) March2 ral Servi	2006 .ce	20c. Location - 0 Alexandr			
Balti	permit. Pages Department of Important: If i eny injury or		21. Signature of Funeral Service License			2. Name and Addre	es Is. Ro		uneral H Republic		20676	
S	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ations that caused the deale cause on each fine. Liver Cal Due to (or as a consect	ncer	ter the mode of dy	ng, such as cardiac	or respiratory a	rest,	1	Approximate Interval Between Onset and Death Years	
8760,	icate be executed physicien and sthe burial-transit	lical Examiner	Sequentially list conditions, I my lead to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consecuence of the consecuence of t							years	
P.O. Box 68	ath certif ttending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a 9 ☐ Unknown	al death 3[Ectopic pregnanc Other (specify)	y		23d. Date Mon	of deliver	y Day Year	
	tuires that the de n signed by the a uld be detached f	þ	Part If. Other significant conditions con	tributing to death but not re	sulting in the u	underlying cause gr	ven in Part I.	23e. Did t	obacco use contri res 2 No		a cause of death?	
Records,		Completed						24a. Was autoj perfo	osy pi rmęd? d	Vere autoportion to come eath?	sy findings available apletion of cause of	
Vita	tician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:		Ott	26. Pface of Dea					
Division of Vital	sing Phys I. After this funeral di	ıtlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Inju	4 Nulsing 11		dence 6 Other			
Divisi		Certification:	3 Surcide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, st	reet, factory, office		28f. Location (City or To	Street and Numbe wn, State)	or Rural	Route Number.	
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one) Certifying Physics 2 Medical Examination (Check only one)	ician: To the best of my kn er: On the basis of examin and manner stated.	owledge, dear ation and/or in	th occurred at the linvestigation, in my	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and mar date and place, a	nner as sta ind due to	ited. the cause(s)	
)	To the within 2 To the complet	Me	29b. Signature and title of certifier	Mayer in)		se number 5823		29d. Date signed 3/1/2006)ay, Year)	
5	+1		30. Name and address of person who co Robert J. Schlager				11 Prince	Frederi	ck MD 20	1678		
A STATE OF THE PARTY OF THE PAR	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrate Sign	ature				20			

		1	For State Registrar		State of M	aryland	-	artmen tificate					Reg. I	IIIII	Suppose	82	91
	Physicia		1. Decedent's Name <i>(F</i>		odore	Tress	sler	Jr.				2. Date of Month Feb	[Day Y 2006	ear	3. Time o	
	/Medic Examin		4a. Facility Name (If no			r)		4b. City,	Town, or	Location of	of Death		4c. County of Death				
	LAdillit	CI.	62 Edwar						hian			Anne Arunde					
F	Funeral Director		5. Social Security Num 199–30–789	1 15	x 7. A ☑M 2□F	Age (In yrs. Ia 66	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of (Month, July	$^{ ext{Birth}}_{Day, Yes}$	1939	Birthp Cour Pe	nna.	or Foreign
	and w	-	Usual Residence of De 10a. State 19	ob. County		10c. City,	Town or Lo	cation							1	Od. Inside C	City Limits
	Maryi	to	MD	Anne Aru	ınde1	Lot	hian									1 🗌 Yes	2 No
	with the	I Direc	10e. Street and Number 62 Edward	er	21401			10f. Zip	Code 2071	1			10g.	Citizen of Wh		ntry?	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "neturel", or itema 23s or 28s-f show other traumatic event, the Madical Exercian must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 3 □ Widowed 4 [12. Was Deceder Armed Force: 1 🔀 Yes 2 [If Yes, Give Year or Dates	s?] No		Was Deced If Yes, spec				ecify Yes or Rican, etc.)	No-	14. Race - Black, Specify:	White,		
5-0	72 ho netur	eted		5. Decedent's Edu			16a. Dece (Give	dent's Usua kind of wo DO NOT us	al Occupa rk done d	ation during mos	it of worki	ng	16b	Kind of Busi	ness/In	dustry	
121	vithin ne. hen	Completed	Elementary/Second		College (1-4o	r 5+)		tary					τ	.S. Na	VV		
N	Hygie Hygie ther t		17. Father's Name (Fin	rst, Middle, Last)	2		7/17 7 7	car y	1001		er's Name	(First, Mid		len Surname)			
Maryland	2 should be filed within and Mental Hygiene. 1s marked other then reumatic event, the M	To Be		heodore	Tress1e	er, Sr.					ginia					iller	
Man	12 sho h and 7 ls mu trauma		19a. Informant's Nam									il Route Nu 1 . MD		y or Town, St 7 11	ate, Zip	Code)	
			Myrna Kay 20a. Method of Dispos 1 □ Burial 2 😾	sition Cremation 3 🗆	Removal from Sta	20b. Pla ce	ace of Disponentery, cre	sition (Nar matory or o	ne of ther plac		March	n 2	20c	Location - C			
Baltimore,	permit. Pages Department of Importent: If i any injury or once.	li	4 □ Donation 5 21. Signature of the	Other (Specify) \$00	Lee		2. Name ar	d Addres			Fune	ral	linton Home C Owin	alv	ert, 1	
			23a. Part1. Enter the shock, or heart f			ed the death								OWIL	190,	Approxima Interval Be	ate
14.8	Physician		Immediate Cause (Findisease or condition resulting in death)			cardia as a consequ			,							Onset and	Death
	/Medical Examiner			ſ						r						1 ve) ca
ŀ	P =	ner	Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or inj	itions, ediate ring	b. Ceren											3 year	
	be executed ician and burial-transit	xam	that initiated events resulting in death) La:		c	as a consequ	-4 <u>-</u>	er	cjen						-		
8760,	ate be ex hysician the buria	dical Examiner		l		nenex									4	3ye	2/1
.O. Box 68	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	by Physician/Med	IF FEMALE: 23b. Was decedent p in the past 12 m 1 □ Yes 2 □ I 9 □ Unknown	onths?		2 ∏ Fetal tat time of de	death 3	⊒Ectopic p ⊒ Other (sµ					_	23d. Date Monti		ery Day	Year
<u>α</u>	equires that the sen signed by th tould be detache	d by Ph	Part II. Other significa	ant conditions of	ontributing to deat	h but not resu	ulting in the u	underlying o	ause giv	en in Part	1.	1		co use contrib 2 DNO 3		he cause of	
Vital Records,	e lav has	Completed										a	Vas an utopsy erformed s 2	P de	or to coath?	opsy finding ompletion of 2 \(\text{No}	s available cause of
ita	ysician: The is certificate director, pag	Be C	25. Was case referre	3			7.				e of Deat	h Check or					
	Physician: this certific ral director.	2	1 ☐ Yes 2 XN	0		atient 2 🗆			_	4014	ursing Ho			e 6 □Other		fy)	
o L	ending P eath. or: After t the funera	lon:															
Division of		Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investigation 6 Could not be determined	28e. Place of	Injury - At ho etc. (Specify							on (Stree Town, S	t and Number tate)	r or Rui	al Route Nu	mber,
	Hospital 94 hours a Funeral I tely filled	edical Ce	29a. Certifier 1 (Check only 2 one)	Certifying Ph	ysician: To the be niner: On the basi and manner	s of examinat	wledge, dea tion and/or i	th occurred	at the tir	me, date a ppinion, de	nd place, ath occur	and due to red at the ti	the caus	e(s) and man and place, ar	ner as	stated. to the cause	n(s)
	To the within 2 To the comple	Med	29b. Signature and ti	tle of certifier?	3.13 .110111101	3,0,00		29	c. Licens	e number			29d.	Date signed	(Month	Day, Year)	
	ĕ → ₹ →		1 h	nlax	(MO	FAC	20		MD 1	5210			F.	66 21	7	200	6
•	(0.1		30. Name av a dres	ss of person who	completed cause	of death (Item	1 23a) (Type	, Print)		10-	e 	- ,					
	10+		31. Date filed (Month	MesECe	32 Ban	istras Sinna	ture	572	د ن در ا	1560	UMIL	10.	O P	4 nedres	4-	AFB	MD
Y.	St Regist	ate rar	JI. Date med (Month)	MAR -	completed cause of 32. Reg	Mesers	, K	1600	Marie B							207	62

			1 - For State Registrar	State of M	aryland		artment rtificate			and M		giene Reg. No. 0	6	08%	92	
	Physici		Decedent's Name (First, Middle VAN CONG VU	Last)							2. Date of Dea	Day	Year	3. Time	of Death	
	/Medic Examin		4a. Facility Name (If not institution,	give street and number)			4b. City,	Fown, or	Location of	of Death	7 0 /	4c. County		1	14-1	
	LAdimin	CI	Shady Grove Ad	ventist Hos	pital		Ro	ckv	ille			Montgomery				
	Funeral Director		5. Social Security Number 224.21.3604		ge (In yrs. Ia:	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day June 8,	rth ay, Year) 9. Birthplace (State or F Country) Vietnam			e or Foreign	
	land		Usuat Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside	City Limits	
	Mary I-f sh	tor	Maryland Montgo	omery	Roc	kvill	е							1 ∑ Y	es 2 □ No	
	th the	irec	10e. Street and Number				10f. Zip	Code				10g. Citizen of V	Vhat Cou	intry?		
	ath wi	ral	15616 Thistleb					853				U.S.A.				
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23e or 28e-f ahow any Injury or other traumatic avent, the Medical Examiner must be notified a once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2⊠ Marrie 3 ☐ Widowed 4 ☐ Diverced	12. Was Decedent Armed Forces? 1 Tyes 2 Till If Yes, Give Year or Dates:	?		Was Deced fYes, spec 1 ☐ Yes 2		spanic Ori n, Mexican Specify:		ecify Yes or No- Rican, etc.)	o- 14. Race - American Indian, Black, White, etc. Specify: Asian				
2-0	72 ho	ted	15. Decedent (Specify only highes			16a. Deced	dent's Usua	l Occupa	ition	t of worki	ina	16b. Kind of Bi	ısiness/lr	ndustry		
21	ithin a.	nple	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of wor)	or works	9	Teleco	mmn	icati	one	
7	iled w tygier thar th	Co	9th 17. Father's Name (First, Middle, L	acti		Me	achini		18 Mothe	r's Name	(First Middle	Maiden Surnan		Icaci		
Maryland	ould be f Mental h arked of	To Be	Trinh Van Vu					4	Buo	ng	Thi Tr	an				
Mar	12 sh h and 7 la m traum		19a. Informant's Name/Relationsh)		-					r, City or Town,			0,	
e,	1 and Healt am 2		Thanh H. Vu/So	11	20b. Pla	ce of Dispo				-	, Silve:	r Spring				
nor	age in a second		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp							3/04	/2006	Silver				
Baltimore,	arit. Portan		21. Signature of Funeral Service L		Jouet	-	-						эргт.	ng, n	17	
ä	Per Per Per Per Per Per Per Per Per Per	8	Nanny A.	Veant		11	LNES-1 1800 1	Jew I	LDI F Hamps	UNER hire	AL HOME	, INC. ilver S	prin	g. MD	20904	
F	Physician /Medical Examiner	resulting in death) Due to (or as a consequence of):										rest,		Approxin Interval I Odset ar	Between	
68760,	cate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions, any, leading to in the distered by the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a conseque	onsequence of):											
.O. Box 6	the death certificat y the ettending phy ched for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months2 1 □ Yes 2 □ 100 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal d	leath 3	Ectopic pre Other (spe					23d. Dai Mo	te of deliv	ery Day	Year	
<u>α</u>	The law requires that the deatt ste has been signed by the ette page 2 should be detached for		Part II. Other significant condition	ns contributing to death t	out not result	ting in the u	nderlying ca	luse give	n in Part I.	,		obacco use cont				
Vital Records,		Completed									24a. Was a autop perfor	med?	Were auto prior to co death?	impletion o	gs available i cause of	
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	_			Othe	-		Check only or					
o	Phys ral dir	7	1 ☐ Yes 2 ☐ 110	28a. Date of Inju	ent 2 El	R/Outpatien 28b. Time of		A Cure Bc. Injury	4 🗀 140	2200		ence 6 Oth		fy)		
o	Attending Phy r death. ector: After thi by the funeral	tion	1 Natural 5 Pending 2 Accident Investig	(Month, Da		Injury	м	Work	?` ′es 2.⊟l		Edd. Dodonog n	ow anjury occur	60			
Division	el or Atten s after deal il Director id in by the	Certification:	3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place of In	jury - At hom tc. (Specify)	ne, farm, str	eet, factory,	, office		1	28f. Location (S City or Tow	itreet and Numb m, State)	er or Run	al Route N	umber,	
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best examiner: On the basis of and manner st	of examinatio	ledge, death on and/or inv	n occurred a vestigation,	it the tim in my op	e, date an inion, dea	d place, a	and due to the ded at the time, d	cause(s) and ma date and place,	nner as s and due t	stated. to the caus	e(s)	
	To ti withi To ti	×	29b. Signature and title of certifier				29c.	License	number		-	29d. Date signe	i (Month,	Day, Year)	
)	8		MA Mark	M.P			5	31	+ /	_	· · · · · · · · · · · · · · · · · · ·	Herma	270	260	ecs	
	V		30. Name and address of person v	the completed cause of the cause of the completed cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause	death (Item 2	23a) (Type,	Print) J	etro	with the contraction	Line.	P. 140	Fesig	,			
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0	32. Figisti	rar's Signatu	4	met	,			,					

		•	For State Registrar	State of Marylar		artment of Hertificate of E		nd Mental	Hygien Reg. N	1000	5 (829	93
	Dhysiair	20	Decedent's Name (First, Middle, Last)		-			2. Date		ay Y	ear	3. Time of I	Death
	Physicia /Medic		George Edward					Feb				6:00	р м
	Examin	er	4a. Facility Name (If not institution, give st 580 Center Dr			4b. City, Town, or Sever			4	c. County of		Arun	dol
	Funeral	100	5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	ff Under 24	Hrs. 8. Date	of Birth			ce (State or	
	Director		216-20-5189	^{M 2□ F} 79	Yrs.	Months Days	Hours	Jun.	h, Day, Yea 30 ,	⁷ 926	Country	MD	
70	S days	}	Usual Residence of Decedent 10a. State 10b. County	10c C	ty, Town or Lo	ecation					100	d. Inside Cit	v Limits
S N	f eho	ō	MD Anne Ar		.,,	Severn	a Parl	k				1 🗆 Yes	
the contract of	r 28a-	Funeral Director	10e, Sfreet and Number			10f. Zip Code			10g. C	Citizen of Wh	at Country	y?	
3	230 o	al D	580 Center Dri	ve		21	146			U	SA		
r dear	eme Br.mi	iner	11. Marital Status	or No-	14. Race - Black,	Americar White, ef							
5-0036	tal Hygiene. d other then "naturel", or iteme 23e or 28e-f ehow event, the Medical Examinat must be notified at	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: W.M.	i	1 ☐ Yes 2 🔀 No				Specify:		Whit	.e
21215-003	aturel cal Es		15. Decedent's Educa	ation	16a. Dece	dent's Usual Occupa	ition		16b.	Kind of Busi	ness/Indu	stry	
215 215	Media Media	plet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done d DO NOT use retired)	<i>luring</i> most o	f working					
	Hygiene ther the	Completed	12		Bui	lding Co				Self-	Emp]	oyed	
שום מו		Be	17. Father's Name (First, Middle, Last)					Name (First, M		en Sumame)			
Maryland	Heath and Mental	မ	Joseph Wilkins 19a. Informant's Name/Relationship (Typ	e. Print)	19b. Maili	ng Address (Street a		Fontz		or Town. St	ate. Zip C	ode)	
	27 th		Scott George Wilki			325 Annry					2735	_	
ē,	Health item 27 other tr		20a. Method of Disposition	20b.	Place of Dispo	esition (Name of matory or other place	-1	Date		Location - Ci			
DOE!	ant: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State MD		ans Cemete		ar. 3, 2006	Cr	rownsvi	ille,	MD	
Baltimore,	Department of I		21. Signal fe of un rat Service Licenses	71h	£ 4	arranco & 95 Gov. R	stans, itchie	P.A. S Hwy, S	everna everna	a Park a Park	Fuel , MD	nral H 2114	
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the dea	th. Do not en	er the mode of dying	, such as ca	rdiac or respirat	ory arrest,		1	Approximate	veen
	hysician		Immediate Cause (Final disease or condition	netos	Inter	Carci	of person	Re	LIV	e =		Onset and D	
-	/Medical xaminer		resulfing in death)	Due to (or as a conse	quence of):								
		er	Sequentially fist conditions, if any, leading to immediate	Due to (or as a conse	quence of):		V						
9	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
. Box 68760,	hysicien and the burial-transit		resulting in death) Last	Due to (or as a conse	quence of):								
8760,	hysici the bu	lical	d.										
X S	anding pl	Mec	IF FEMALE:	c. If yes, outcome of pregr	2004								
Box	attending p	iclan/Med	in the past 12 months?	1 □ Live birth 2 □ Fet 4 □ Pregnant at time of	al death 3	Ectopic pregnancy Other (specify)				23d. Date of Month	,		'ear
		Physi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown				7-1-1					
I Records, P.O	igned be deta	by P	Part II. Other significant conditions cont	nbuting to death but not re	sulting in the u	inderlying cause give	n in Part I.	23e.	Did tobacco	o use confrib	ute to the	cause of de	eath?
ord S	been sig							_	1 Yes	2 □ No 3	Probab	oly 4 XIU	Inknown
Records,	has be je 2 sh	Completed						24a.	Was an autopsy	prie	or to com	y findings a pletion of ca	ivailable luse of
								10,	performed? Yes 2121		ath?] Yes 2	□ No	
Vital	certificate irector, pag	9 Be	25. Was case referred to medical examiner? 1 ☐ Yes 2₺ No	ospital:	7500	othe Othe		t Death Check	7	2 Flore	(5 ()		_
o §	er this	n: To	27. Manner of De ith	28a. Date of Injury (Month, Day Year)	28b. Time o	11 3 DOA	4 INUIS	ing Home 5 2		fury occurred			
vision of Vita	ath. rr. Atter se tuner	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day Fear)	Infury		res 2 □ No						
Division of	after death Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of friury - At I building, etc. (Spec	nome, farm, st	reet, factory, office			tion (Street or Town, Sta	and Number ate)	or Rural	Route Numl	ber.
	ours a erai D		29a. Certifier Certifying Physi	cian: To the best of my kr	voyaledge, deal	h accurred at the tim	o data and	place, and due :	o the cours	(a) and man	or or ato	tod.	
T Joseph ett of	within 24 hours after deat To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Examin	er: On the basis of examin and manner stated.	ation and/or in	ivestigation, in my op	oinion, death	occurred at the	time, date a	ınd place, an	d due to t	he cause(s)	
,	To	-	29b. Signature and title of pertilier	MA	1	29c. License	3/5	3-1	70	Date signed (H /	LOC4	5
	-31		30. Name and address of person who cor	npleted cause of death (Ite	170 T	Print) DOW	4, 6	fen B	inny	14.	210	6/	
10 mg	Sta Registi		31. Date filed (Month, Day, Year)	32 degistrar's Sign	nature	harde	,						

		•	1 - For State Registrar	State of	Marylan		artment rtificate			and M		giene Reg. No.	06	0829) l ₄
	Physici	an	1. Decedent's Name (First, Middle, Las	,							2. Date of Dea Month	Day	Year	3. Time of	
5	/Medic	_	Charlotte Marie				45 63 7		1	(5-1)	March	01	2006 ounty of Deatl	8:15	a ^M
	Examin	er	4a. Facility Name (If not institution, give Long View Nursing		er)				Location on the control of the contr			40.00	Carro		
	Funeral	- 100 E	5. Social Security Number 6. Se		Age (In yrs. I	ast birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birt	h	9. Birth	nplace (State or	r Foreign
	Director		156-18-1229	□ M 2 □ x =	82	Yrs.	Months	Days	Hours	Min.	(Month, Da August	7 19	23	Wisc	٥.
	pur *		Usuel Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation							10d. Inside Cit	v Limits
	daryli f •ho	5	MD Carro	.11		Westm:	_							1 🗆 Yes	
	1 the 1	rect	10e. Street and Number			110001	10f. Zip					10g. Citize	n of What Co	untry?	
	th with	aD	1095 Heather Dr	ive				23	1158				USA		
336	be filed within 72 hours after death with the Maryland stal Hygiene. ed other then "netural", or iteme 23e or 28e-f ehow event, the Markal Examinar must be multied at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	ss? X No		Was Decede If Yes, speci 1 Yes 2		spanic Ori n, Mexican Specify:		cify Yes or No Rican, etc.)		Black, White	American Indian, White, etc. White	
0-10	2 hour	ted	15. Decedent's Ed			16a. Dece	dent's Usua	l Occupa	tion	t of worki	na	16b. Kind	of Business/l	ndustry	
21215-0036	within 7 ene. then "r	Completed	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+) (Give kind of work done during most of working life. DO NOT use retired) Flood Somuting											1.	-
12	e filed within al Hygiene. I other then '		17. Father's Name (First, Middle, Last)			1	Food S	erv		ar's Name	(First, Middle,			H os pita	.1
anc	d be f intal h	Be C				,,,,,,,,									
Maryland	s 1 and 2 should be f Health and Menta item 27 ts marked other traumatic ex	ဥ	Frasier Hollenb 19a. Informant's Name/Relationship (7	eck Type, Print) d	auchte	19b. Maili	ng Address	(Street a	IMA1 and Numbe	ude (er or Rura	Gilling I Route Number	S er, City or T	own, State, 2	ip Code)	
	od 2 lith a 27 ts r tre		Doris Wolthouse-K		n law				Dri	ve T	westmin.	ster,	MD 2	1158	
ore	@ O	l i	20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from St:	ce Ce	lace of Disponentery, cre-	matory or ot	her plac	· I		ate 3, 20	06c. Loca	tion - City or	Town, State	
Ë	Pages ment of tent: If it		4 Donation 5 Other (Specify		Me	adow I			-	•			minste	r, MD	
Baltimore,	permit. Page Department Importent: if eny injury o		21. Signature of Funeral Service Licen	500		1	ritts	Ardres	iera I	ty Home	and C	hapel	, P.A.		
	-		23a. Part1. Enter the disease, or comp	olications that cau	sed the death						West		er, MD	21157 Approximate	•
	Dhusisian		shock, or heart failure. List only in Immediate Cause (Final	one cause on eac	h line.	inm	-1100	att	1.1		,			Onset and D	
$\int \mathcal{E}_{j}^{+}$	Physician /Medical		disease or condition resulting in death)	a. Due to (or	as a consequ	uence of):	dob	100	3	1					
	Examiner		Conventially list conditions	" End	1 st	age	Re	rec	1	dis	6436	_	1		
	p ii	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequ	ience of):									
	and and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	as a consequ	ieuce of).									
8760,	cate be executed physicien and the burial-transit	cal E	l	200 (0 (0)	20 2 30004	201.00 0.,.									
687	ficate g phys			_ d											
Вох	death certifics e ettending ph ad for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	me of pregna		∃Ectopic pre	2022204				230	d. Date of deli		
-	that the death ed by the ette detached for	sicis	in the past 12 months? 1 ☐ Yes 2 🕅 No		t at time of de		Other (spe						Month	Day Y	'ear
P.O.	d by the	Phy	9 □Unknown ' Part II. Other significant conditions o			ulting in the c	and orbital on		n in Dart I		23a Did t	obacco use	contribute to	the cause of de	eath?
ds,	9 G	d by	Carchexi	A .	ar but not rest	aiting in the t	inoonying co	iuse give	311 III 1 GERCE				No 3□Pr		nknown
Sor	v requir been s should	ete									24a. Was	an :	24h. Were au	topsy findings a	available
Records,	The lay	Completed									autor perfo	osy ormęd?	prior to death?	completion of ca	iuse of
ta	ician: T certificet ector, pa	a	25. Was case referred to medical						26. Place	of Death	1 Yes	22 No	1 🗆 Yes	2/A No	
of Vital	8 × 5	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 🗆 Inp	atient 2	ER/Outpatie	nt 3 DO	A Othe	91: 4 Nu	ursing Ho	me 5 Resi	dence 6[]Other (Spe	city)	
0 1			27. Magner of Death Natural 5 Pending	28a. Date of (Month,	Injury Day Year)	28b. Time o	of 28	8c. Injury Work	at		28d. Describe	how injury o	occurred		
sio	Attending For death. ector: After by the funera	catl	2 Accident investigation 3 Suicide 6 Could not be				М		Yes 2		206 1	<u> </u>			
Division	or A liter Direct in by	Certification;	4 Homicide determined	286. Place of	Injury - At ho , etc. <i>(Specif</i>)	ome, farm, st	reet, factory	, office			28f. Location (: City or To		vumber or Hu	rai Route Numi	oer,
_	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edical Co	29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the be niner: On the basi and manner	is of examinat	wledge, deat	h occurred a	at the tim in my of	ne, date an pinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s) ar date and p	nd manner as lace, and due	stated. to the cause(s))
	To the within To the comple	Me	29b. Signature and title of certifier	XA 8 00	\(\sigma\)		29c	License	number			29d. Date	signed (Mont)	n, Day, Year)	
	MISU		> (reference)	what in	リ			0			5		2-0	6	
	W 3		30. Name and address of person who	+ 349	Ma	1001		2 /	Me	str	rinstr	2_	WD	2115	7
	Sta Registi		31. Date filed (Month, Day, Year) MAR 0 2	2006 32. Reg	istrar's Signa	ture	Core	ر							

	Pleas	se Type or I	Print in B	lack Inc	delible	ınk.	Ensu	re Al	I Copies	Are	e Legi	ible.	
. For		State of	Maryland	i / Depa	rtmen	t of H	lealth a	and M	lental Hy	gien	е		
1 - Stata Registrar			•				Death		,	Rag. N		16	08295
1. Decedent's Name	First, Middle	, Last)							2. Date of De		av	Year	3. Time of Death
LI	EON W	ROTEN, S	SR.						03			006	1138 AM
4a. Facility Name (/	f not institution	, give street and num	iber)		4b. City,	Town, or	Location o	f Death		4	c. County	of Deat	h
Memoria	il Ho	spital o	it East	an							T	albi	ot
5. Social Security N 214-28-8	umber	6. Sex- X EXM 2□F	7. Age (In yrs. Ia 8	st birthday) 1 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Mav 1	y, Yea	924	9. Birtl Co Mar	hplace (State or Foreign untry) yland
Usual Residence of													
10a. State	10b. County		10c. City,	Town or Loc	cation								10d. Inside City Limits
MD	C	Caroline				F e	edera	ılst	urg				1X Yes 2 □ No
10e. Street and Nur	nber				10f. Zip	Code				10g. C	itizen of	What Co	untry?
325	Buena	Vista Av	enue			2	1632			Un	ite	1 St	tates
11. Marital Status	v	Armed For	dent Ever in U.S		Vas Deced Yes, spec	ent of H	ispanic Orig	gin? (Sp., Puerto	ecify Yes or No Rican, etc.))-		e - Ame	ncan Indian,
1 ☐ Never Marri 3 ☐ Widowed		ied 1 □ Yes If Yes, Give Year or Da	9	1	☐ Yes 2	No No	Specify:				Specif	1.71	nite
(Spec	15. Decedent ify only highes	's Education t grade completed)		16a. Deced (Give I	enl's Usua kind of wor	l Occup	ation during most f)	of work	ing	16b.	Kind of 8	usiness/l	Industry
Elementary/Seco	ndary (0-12)	College (1	-4or 5+)	III e. L	Farı		1)			Ag	ric	ı1tı	ıre
17. Father's Name	First, Middle, I	Last)					18. Mothe	r's Name	e (First, Middle	, Maide	n Suman	ne)	
Rando	lph W	Iroten					El	Lva	Moore				
19a. Informant's Na	me/Relationsh	nip (Type, Print)		19b. Mailin	g Address	(Street	and Numbe	r or Run	al Route Numb	er, City	or Town,	State, Z	Tip Code) 21632
Helen 1	Wroten	/Spouse		325	Bue	na '	Vista	а Ал	enue,	Fe	dera	alst	ourg, MD

29b. Signature and title of certifier

Timothy J. S 31. Date filed (Month, Day, Year)

MAR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

Sniezek

6 2006

Physician

/Medical

Examiner

Funeral

Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit Division of Vital Records, P.O. Box 68760,

ס		Usual Residence of De	cedent											
with the Maryland a or 28a-f show be notified at	. _		b. County	1:	10c. City	, Town	or Location	D . J .	1 . L					10d. Inside City Limits
e Ma	Director	MD	Car	oline				rede	eralsb	urg				1X Yes 2 □ No
ith th	Dire	10e. Street and Number	r				10f. Zip C				10g. Ci	tizen of Wh	at Cou	ntry?
238	la l	325 Bu	ena Vi	sta Aver	ue			2163				ited	St	ates
r deg	Funeral	11. Marital Status	v	12. Was Decedent 8 Armed Forces?	Ever in U.	S.	 Was Deceder If Yes, specify 	t of Hispani Cuban, Me	c Origin? (Spec xican, Puerto F	cify Yes or No lican, etc.))-	14. Race - Black,		
72 hours after death with the Maryland nature!; or items 23a or 28a-f show deat Examinar nast be notified at	Ď	1 ☐ Never Married 3 ☐ Widowed 4 ☐		1 □ Yes 2 ☑ N If Yes, Give Year or Dates:	10		1 □ Yes 20							ite
n 72 h	Completed	(Specify o	. Decedenl's Edu only highest grad	e completed)		16a. I	Decedenl's Usual (Give kind of work life. DO NOT use	Occupation done during retired)	most of workin	g	16b. K	(ind of Busin	ness/ir	dustry
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 le marked other than "eny injury or other treumatic event, the Magnes.	Somp	Elementary/Seconda	ry (0-12)	College (1-4or 5	+)		Farm				Ag	ricu1	tu	re
at Hy	Be (17. Father's Name (Firs	st, Middle, Last)					18. N	Mother's Name	(First, Middle	, Maider	n Sumame)		
should bind Ment	2	Rando1p	h Wro	ten					Elva I	Moore				
2 sho and ie m	. 9	19a. Informant's Name	Relationship (T)	pe, Print)		19b.	Mailing Address (S	treet and N	umber or Rural	Route Numb	er, City	or Town, St	ate, Zij	Code) 21632
alth alth er tr		Helen Wr	oten/S	pouse		3	25 Buen	a Vis	sta Av	enue,	Fe	deral	Lsb	urg, MD
oth oth		20a. Method of Disposit			20b. P	ace of	Disposition (Name r, crematory or other	of er place)	Da	ate	20c. L	ocation - Ci	ty or To	own, State
Pages nent of int: if its		4 Donation 5		Removal from State	1		Crest C		3/5/	06	Fe	dera]	lsb	urg, MD
permit. Departn Imports eny inju		21. Signature of Funera	al Service Licens	ee			22. Name and		acility					
88 E 8 8		Christ	Time n	1. Coal	e		Frampt	om Fι	ıneral	Home	, F	edera	1s	burg, MD
3- 1		23a. Part1. Enter the d	lisease, or compliture. List only o	ications that caused ne cause on each lin	the death	n. Do no	ot enter the mode	of dying, suc	h as cardiac or	respiratory a	rrest,			Approximate Interval Between
Physician		Immediate Cause (Finadisease or condition		Acute		A.A	1/00)	1	10 f	-10				Onset and Death
/Medical		resulting in death)	-	Due to (or as		ience o	yourdia	1	IVI TEUC				+	30-111
Examiner				Coro			Arter		Diseas	e				10 1.15
	Jer	Sequentially list conditi if any, leading to immediate. Enter Underlyin Cause (Disease or injur	diate	Due to (or as		ence o	n:							· · y · s
uted	Examine	Cause (Disease or injuit that initiated events	ry 1											
execting an an ial-tr	Exa	resulting in death) Last		Due to (or as	a consequ	ieuce o	f):							
The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use es the burial-transit	cal			d										
ifficating physics the sth	Physician/Medical													
h cer andin use	2	IF FEMALE: 23b. Was decedent pre	egnant 2	3c. If yes, outcome			2 DEstanta cons					23d. Date o	f deliv	ery
death e atte	icia	in the past 12 mor 1 ☐ Yes 2 ☐ No	aths?	1 ☐ Live birth 4 ☐ Pregnant at			3 □Ectopic preg 5 □ Other (spec					Month		Day Year
w requires thet the de been signed by the should be detached	hys	9 🗆 Unknown		9□ Unk/lown										
s the	by P	Part II. Other significan	nt conditions co		ut not resu	ılling in	the underlying cau	se given in F	Part I.	23e. Did t	obacco	use contribu	ite to t	he cause of death?
quire on sig uld b	ed t	Polycythe	emi A	VERA						10	Yes 2	□No 31	rot	oably 4 □Unknown
law reas bee	Completed	Hyperten	15100							24a. Was	an	24b. We	re auto	ppsy findings available
The la	E	11 0001	` 0 = (rmed?	prio	r to co th?	opsy findings available impletion of cause of
	Ö	25. Wa se referrant	1 DEMIF	1	-				Discoult Discoult	1 ☐ Yes		1	Yes	2 No
Attending Physician: r death. ector: After this cartific by the funeral director,	0	examiner?	-	lospital:	et 2 1714	ER/Outs	patient 3 DOA	Other	Place of Death			A [] Out	· O · · · ·	7
Phy	-	27. Manner of Death	_	28a. Date of Injur (Month, Day		28b. Ti		Injury at Work?	Nursing Hom	Bd. Describe I			Specii	y)
ding F th. After funeri	Ş	1 ☐Natural 5 2 ☐ Accident	Pending investigation	(Month, Day	Year)	In	jury M	Work? 1 ☐ Yes	i			,		
deal ctor y the	fica	3 Suicide 6	Could not be	28e. Place of Inju	ırv - Al ho	me, fari	m, street, factory, o	ffice	21	Bf. Location (Street ar	nd Number	or Rura	al Route Number,
pital or Attenous after deat eral Director; filled in by the	Certification	4 Homicide	derettillied	building, etc	. (Specify)				City or To	vn, State	a)		
Hospital or Attendid 24 hours after death. • Funeral Director; A etely filled in by the fu		29a. Certifier 1	Certifying Phy	sician: To the best of	of my know	wledge	death occurred at	the time dat	te and place ar	nd due to the	Causals) and mage	91255	tated
the Hos hin 24 h the Fur mpletely	edicai	(Check only 2 one)	Medical Exami	ner: On the basis of and manner sta	examinat	ion and	or investigation, in	my opinion,	death occurre	d at the time,	date an	d place, and	due to	the cause(s)
o the ithin 2 o the omplet	Me	29b. Signature and title	of certifier	A 1			29c. L	icense num	ber		29d. Da	te signed (A	Month.	Day Year)

29c. License number

AUE

00053253

Preston,

29d. Date signed (Month, Day, Year) 03/03/06

MO

State

Registrar

136 Ledrum

		•	1 - For State Registrar	State of Ma	aryland			of Healt		-	giene Reg. No	MAG	08296
	8. 1		Decedent's Name (First, Middle, Li	ast)				0. 500		2. Date of De		000	3. Time of Death
П	Physici	an	A 1	T	1	0,15	· ~ m			Month	Day	Year	0555A
4	/Medic		4a. Facility Name (If not institution, gi	va straat and number)		~ (15		own, or Local	tion of Death		40.0	ounty of Death	
	Examin	er	Coastel Her pre	at the	Lak	2	40. Oity, 10	Sals	bury		40. 0	WICEY	1116
	Funeral Director		5. Social Security Number 6. 218–20–9610	Sex 7. Age 7. Age 7. Age 7.	e (In yrs. las	st birthday) Yrs.	If Under 1 Months	Year If Ur Days Hot	nder 24 Mrs. urs Min.	8. Date of Bir (Month, Da 2/8/19	v Year)	Cou	place (State or Foreign intry) yland
	D .		Usual Residence of Decedent										
	how		10a. State 10b. County			Town or Lo							10d. Inside City Limits
	e Ma	5	Maryland Wicom	100	Sa	alisbu	ıry						1 ☐ Yes 2/CxNo
	or 2	Funeral Director	10e. Street and Number				10f. Zip C				10g. Citize	en of What Cou	intry?
	23a	ie l	1031 Caravan Wa	У				1804			US		
	en a	Ine	11. Marital Status	12. Was Decedent E Armed Forces?		. 13. \	Was Deceder	nt of Hispanio y Cuban, Me:	c Origin? (Sp xican, Puerto	ecify Yes or No Rican, etc.)	- 14	 Race - Ameri Black, White 	
36	or if	by Fi	1 Never Married 2 Married	1 ☐ Yes 2 📉 N If Yes, Give	10		1 ☐ Yes 2	☐ No Spe	ecify:		S	Specify:	nite
8	hour uret	D D	3 Widowed 4 Divorced	Year or Dates:	1	160 D	dente Herrel	0			1.Ch Kin		
5	n 72	iete	15. Decedent's E (Specify only highest g			(Give	dent's Usual kind of work DO NOT use	done durina	most of work	ing	160. Kind	d of Business/Ir	ndustry
21215-0036	e filed within 72 hours after deeth with the Maryland Hygiene, Hygiene, 14 hygiene, 19 how I other then "naturel", or lieme 23e or 28e-f ehow vent, tre Medical Examinar must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)			on Eng	ineer		State	. Hiahw	ay Admin.
S	filed Hygir Sther ent,		17. Father's Name (First, Middle, Las	t)						e (First, Middle,			
/lan	ould be Mental Arked o	To Be	Norman L. Wilso						Eva Ru				
=	and and m		19a. Informant's Name/Relationship Darlene J. Wilso				-			al Route Numbe isbury,			ip Code)
ď	of Heelth of Heelth item 27 t		20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Name	of		Date		ation - City or T	own, State
altimore,	Pages nent of I int: If it		1 Burial 2 Cremation 3		1 .		natory or oth Crema	- '	3/4/	106			
를	artme orten injury		4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Sice	•	Dall			Address of F		00	Saı	isbury	, MD
Ва	permit. Pages Department of the importent: If its eny injury or of pages.		N 20 0 (1)	wey CES	0	Ho	olloway	v Fune	ral Ho	me Prof Salisbu	essic	nal As:	sociation
- 5			23a. Part1. Enter the disease, or cor shock, or heart failure. List on	nplications that caused	the death.	Do not ent	er the mode	of dying, suc	h as cardiac	or respiratory a	rrest,	D-2100-	Approximate Interval Between
M.C.	Physician		Immediate Cause (Final disease or condition	AHZ	hoin	e.le	\mathcal{N}	15cm	0				Onset and Death
	/Medical		resulting in death)	Due to (or as	a conseque	nce of):		13625					- 412
1	Examiner			b									
· A		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	a conseque	nue of).							
	cutec nd ransi	Examiner	Cause (Disease or injury that initiated events	c.									
0	e exe ian a irial-i		resulting in death) Last	Due to (or as a	a conseque	ince of):							
8760,	cate be executed oblysician and the burial-transit	dicai		d									
9	ing p	Mec	IF FEMALE:								-10		
Вох	death certific e attending p d for use as	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth		death 3	Ectopic preg				23	d. Date of deliv	very Day Year
	0 0	Physician/Me	1 Yes 2 No	4□ Pregnant at 9□ Unknown	time of dea	ith 5□	Other (spec	cify)				WORTH	Day
P.0	that the de ed by the detached	P.				i - t- t			N- 41	oza Dida			Mb = 4 = -4 = -4 = -4 = -4 = -4 = -4 = -4
s,	Se us	þ	Part II. Other significant conditions	contributing to death bt	ut not result	iing in the ui	nderlying cat	use given in F	-aπ I.			1	the cause of death?
orc	w require been si should I	ted								10	105 25	₩ 3∐ F10	Joanny 4 Dorknown
Vital Records,	has b	Completed								24a. Was autor	osy	prior to co	opsy findings available ompletion of cause of
<u> </u>	pa ate	Son								1 ☐ Yes	rmed? No	death? 1 ☐ Yes	2 No
/ita	ysician: Th	Be	25. Was case referred to medical examiner?						Place of Dea	th (Check only o	(00)		
of \	Physician: this certific al director.	2	1 ☐ Yes 2 No	Hospital: 1 Inpatre	nt 2□E	R/Outpatien			Nursing H	ome 5 Resi	dence 6	□Other (Speci	ify)
		OD:	27. Manner of Death SNatural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 2	8b. Time of Injury		c. Injury at Work?		28d. Describe	how injury	occurred	
Sio		cati	2 Accident investigation				М	1 Tyes	2 🗆 No				
	or Atten after deat Director: I in by the	Certification:	3 Suicide 6 Could not determined	28e. Place of Injubuilding, etc		ne, farm, str	eet, factory,	office		28f. Location (. City or Tox		Number or Rur	ral Route Number,
	oital o												
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai	29a. Certifier (Check only one) Gertifying P Medical Exs	hysician: To the best of miner: On the basis of and manner sta	examinatio	ledge, death on and/or inv	h occurred at vestigation, in	the time, dat n my opinion,	te and place, , death occui	and due to the red at the time,	cause(s) a date and p	nd manner as s lace, and due	stated. to the cause(s)
	within 2 within 2 To the comple	Me	29b Signature and title of senifier				29c.	License num	ber		29d. Date	signed (Month,	, Day, Year)
	⊢ ≯ ⊢ ŏ		1/2)(15	011	NAM	1				18			
	0	1	30. Name and address of person who	completed cause of d	eath (Itom 1	23a) /Tunn	Print)	00	27 0 1		7	70	
_	To		Devil E. Coual,	M Coasted	/ 11	W	Po:	BUX 1	733	Sal	ish	Cm,	-06 2180L
	Sta Registr	-	31. Date filed (Month, Day, Year) MAR 0 3	2006 32. Registra	ar's Signatu	ire						/	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of W	aryiari		rificate of	Death		eg 2000 6	082	297
			1. Decedent's Name (First, Midd	lle, Last)					2. Date of Dea	th		e of Death
	Physici		GERALD SALE	M WARNER					Month	8 200	6 9:	20 p.m.
3-	/Medic Examir		4a Facility Name (If not institution)			4b. City, Town, or	Locetion of Death	4c. County of		
7			Devlin Manor	Nursing Hom	ne			Cumber	land	A1	legany	
	Funeral		5. Social Security Number	6. Sex 7. Ag		last birthday)	If Under 1 Year Months Days	If Under 24 Hrs	8. Date of Birth		9. Birthplace (Sta Country)	te or Foreign
	Director		234-54-0838	10XM 2□ F	74	Yrs.	Williams Baye	7,100,10	June 18		Whitmer,	
	pu 🛾	.	Usual Residence of Decedent 10a. State 10b. Count		100 Cit	y, Town or Loc	ation				10d Insid	e City Limits
	anyle shor	-			100.00							res 2121 No
	Ne M 188-1	Director		ker		Eglon						-75
	Mit v	ă	10e. Street and Number				10f. Zip Code		'	0g. Citizen of Wh	at Country?	
	s 23	Funeral	Rt. 2, Box 2	70-F	From in 11	C 40 W		716	Procify Voc or No.	USA	American India	
	er de	Š	11. Marital Status	Armed Forces?	?	,5. 13. W	Yes, specify Cul	Hispanic Origin? (S can, Mexican, Puer	to Rican, etc.)		White, etc.	1,
20	ours after death with the Marylen rat, or Items 23e or 28e-f show Examiner must be notified at	by F	1 X Never Married 2 Ma 3 Widowed 4 Divorce	If Yes Give	140	11	☐ Yes 21 No	Specify:		Specify:	White	
ş	n 72 hours after death with the Marylend "netural", or Items 23a or 28a-f show saftal Examiner mast be notified at	8	0.000	nt's Education		16a. Decede	nt's Usual Occu	pation		16b. Kind of Busi		
75	in a	Completed	(Specify only high	est grade completed)	e.\	(Give k life. De	ind of work done O NOT use retin	ipation a during most of wo ed)	orking			
5	filed within Hygiene. thar than " ant, the Ma	E	Elementary/Secondary (0-12)	College (1-4or	J+)	Far	m Labor	er		Self E	mployed	
פ	be filed within 7 ttel Hygiene. d other then "n	Be C	17. Father's Name (First, Middle	, Last)				18. Mother's Na	me (First, Middle,			
<u> a</u>		2	Adam Harness	Warner				Jessie	Elza			
a	d 2 should th and Mer 7 is marks traumatic		19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailing	Address (Stree	t and Number or R	ural Route Numbe	r, City or Town, Si	tate, Zip Code)	
Σ	1 and 2 Health em 27 i		Douglas Warne	r		1240	3 Dusty	Lane Fu	ılks Run,	VA 228	30	
ore	of He item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 Demous I from State		lace of Disposi emetery, crema	ition (Name of atory or other pl	ace)		20c. Location - C	ity or Town, State	•
Ĕ	Pag nent int: If		4 □ Donation 5 □ Other (urel Hi	lls Cem	etery	March 11 2006	Whitmer	, WV	
Baltimore, Maryland 21215-0020	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		21. Signature of Funeral Service	Licensee		22.	Name and Addr	ess of Facility T	omblyn F	uneral H	ome	
m	8 2 E 8 8		Bull	JA Suit	11		45 Rand	olph Aven	-		26241	
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that cause	d the deatl							mate Between
	Physician		SHOCK, OF HEART failure. Lis	torny one cause on each	iiie.						Onset a	nd Death
	/Medical		Immediate Cause (Final disease or condition	- 2	-1	- 0	main	minet	L .		year	~
	Examiner		resulting in death)	a. Ju	Due to (o	r as a consequ	ence of):	10	7			
\mathcal{T}	p tis	Examiner		- h atten	selen	te Co	dura	when de	2000-		yen	~
V	rificete be executed ng physician and s as the burial-transit	хаш	Sequentially list conditions,		Due to (o	r as a consequ	ence of):					
90	be e) ician buria	ᄪ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	c								
68760,	phys the	edical	that initiated events resulting in death) Last		Due to (or	r as a conseque	ence of):				į.	
×		5		d							· · · · · · · · · · · · · · · · · · ·	
Box	atten for u	clar							F-11-11-11			
P.O.	The law requires that the death ce are has been signed by the attending page 2 should be detached for use	Physician/I	Part II. Other significant conditi	ona contributing to death b	out not resi	ulting in the und	derlying cause g	iven in Part I.		obacco usa contr		
٣.	that the policy of the policy details	4	Chrone lyn	projetie en	Men	ed! ry	penta		1 🗆 Y	as 2 to 3	□ Probably	J □ Onknown
Division of Vital Records,	uires sign	Completed by	0 (,		0	/		24a. Was a	n autopsy	24b. Were autop	
Ö	beer beer shou	ete	proumou	CHF					perfor	med?	available pr completion of death?	
æ	The law ate has page 2:	E	0						1TIY	~	1 ☐ Yes	0
g	i icien : The certificate rector, pag		25. Was case referred to medical	N .				00 Dian of Da			I LI TES	
₹	sicial certi irecto	Be G	examiner?	Hospital:	ont 0□	ER/Outpatient	3□ DOA O		ath <i>(Check only or</i> Home 5□ Resid		(Engoibe)	
ō	Physical distribution	5	27. Manner of Death	1 ☐ Inpati	ıry	28b. Time of	28c. Inju			ow injury occurred		
o D	ding th. Afte	텵	1 Avatural 5 Pendi 2 Accident invest		y Year)	Injury		ork?]Yes 2 □ No				
S	Attending Physician: or death. ector: After this certific. by the funeral director,	lica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of In	jury - At ho	ome, farm, stree	et, factory, office		28f. Location (S	treet and Number	or Rural Route I	Vumber,
á	affer Dire	Certification:	4 Homicide	building, et	c. (Specify	V)			City or Tow	n, State)		
	To the Hospital or Attending Physicien: within 24 hours after deals at 16 deals. To the Funerel Director: After this certification in the funeral director, completely filled in by the funeral director,			ng Physician: To the best								00(0)
	ha Hk in 24 ha Fu pletel	edicai	(Check only 2 Medical one)	Examinar: On the basis o and manner st		tion and/or inve	stigation, in my	opinion, death occi	urred at the time, d	ate and place, an	a due to the cau	se(5)
	with To th	Σ	29b. Signature and title of certific	er 9 .)			se number		9d. Date signed (r)
			>	Ellen hi	,		D	001756.	,	Mer.	1,2006	
	6	f	30. Name and address of persor	· ·			rint)	Duy L		-		
	Ψ		AJDA11i,		122	Neti.	nzi t	try L.	10212	UD 9	1502	
	Sta Registr		31. Date filed (Month, Day, Year	2006 3 Registr	rar's Signa	ture /	de l'					

06-1836 B.K.S UNK Rau1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

-	Type of Finiting Die	ok machbic		oui c Aii	Copics	AIC L	Calir
	State of Maryland	Department	of Healt	h and Me	ental Hyg	jiene	n

aryland / Department of Health and	Mental Hygiene	09295
Certificate of Death	Reg. No.	00600

Aı	rellanc)	1 - For State Registrar	State of N	narylan	•	artment of F rtificate of		ı mental H	ygiene Reg. No.	006	08298
H	Physici	an	Decedent's Name (First, Middle, La	ast)					2. Date of D	Day	Yeer	3. Time of Death
	/Medic Examir		Raul Rosales Are 4a. Fecility Name (If not institution, gi	ve street and numbe			4b. CIX LOWN	r Location of De	MARC ath		, 2006 County of Death ONTGOMEI	12:59 A ^M
			WASHINGTON ADVE 5. Social Security Number 6.			last birthday)	If Under 1 Year	If Under 24 H				
	Funeral Director			1 M 2 □ F	25	Yrs.	Months Days	Hours Mi	n. (Month, L	Day, Year) 21,198	30 Mex	place (State or Foreign ntry) KICO
	P .		Usual Residence of Decedent		5.53	-						
	e-f ehov	ctor	10a. State 10b. County Maryland Montgo	merv	100. CII	y, Town or Lo Silver	Spring					10d. Inside City Limits 1 ☐ Yes 2 X No
	or 28	Director	10e. Street and Number	_			10f. Zip Code 209	Λ2		-	en of What Cou	ntry?
	• 23e	ral	8230 New Hampshi		A Constitution	6 42			(Canada V-a -a 8		KICO 4. Race - Ameri	ana ladina
136	172 hours after death with the Maryland "natural", or fleme 23a or 28e-f ehow solical Examinal must be notitied at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 Tyes 25 If Yes, Give Year or Dates	s?		Was Decedent of HII Yes, specify Cub	Specific	erio Rican, etc.) exican	1	Black, White,	etc.
Š	72 hou	ted	15. Decedent's E (Specify only highest gi	ducation		16a. Dece	dent's Usual Occup kind of work done	nation	vorkina	16b. Kind	d of Business/Ir	ndustry
9500-61212	withir Bne. then	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	nknown	d)	ioning	ur	nknown	
Maryland	T C .	To Be C	17. Father's Name (First, Middle, Las Juan Rosales Vil					18. Mother's N	lame (First, Middi ina Flo		_{Sumame)} Arellanc	
a _Z	ss 1 and 2 should of Health and Mer litem 27 le marke r other traumatic	_	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street			ber, City or	Town, State, Zij	o Code)
	and 2 ealth m 27 her tra		Ruben Rosales Ar	ellano, B	rother	40 Ir	ving Ave	nue, Bro				
Baltimore,	t of H if ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [Removal from Stat	a C	cemetery, crei	natory or other pla		Date 22/06		ation - City or T	
	permit. Pages Depertment of Inportent: If Ite any Injury or of angles.		4 Donation 5 Other (Spec		Œ		Morelos Name and Addre				s, Mexico	
ğ	Per Oppose	1	> Junghat	11)1113		2. Name and Address 1.7 Central					
			23a. Part1. Enter the disease, or con shock, or heart filure. List only								lacie III de Tr	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	-a Hea	4	njur						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	is a conseq	juence of):						
T	sit s	lner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to lor a	is a consac	uence of):						
٧	xecut	Examiner	that initiated events resulting in death) Last	c. Due to (or a	is a conseq	uence of):						
09/89	tificate be executed g physician and as the burial-transit			. d								
-	rtificat ng phy as the	Aedical	IS SECULIE	- 0.								
O. Box	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	Ideath 3	Ectopic pregnanc Other (specify) _	y		23	3d. Date of deliv Month	ery Day Year
ecords, P	w requires that been signed b should be deta	b	Part II. Other significant conditions	contributing to death	but not res	ulting in the u	ndertying cause gr	ven in Part I.		tobaccous]Yes 2 ሺ		he cause of death?
ပ္တ	S S S	Completed							24a. We	as an	24b. Were auto	opsy findings available ompletion of cause of
Y,	Fage page	Com							10X Yes	formed?	death?	
VItal	Physiclan: this certific ral director,	Be	25. Was case referred to medical examiner?	Honoital:			104		eath (Check only	one)		
0	Phy this	2	Yes 2 No 27. Manner of Death		X	ER/Outpatier 28b. Time o		4 🗆 140131119	Home 5 Re			
DIVISION	Attending Firdeath. ector: After by the funer	Certification;	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigate 3 ☐ Suicide 6 ☐ Could not	7 00		15:12	AM 1	rk? Yes 2 No	passener	of a	mutor of	which that
2	tal or A	Certif	4 Homicide determined	building,	etc. (Specif	Ro	reet, factory, office ad		City or T	own, State)	Metzero	ott Rd and
)	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (29a. Certifier (Check only one) 1 Cartifying P 2 Medical Exa	hysician: To the bes minar: On the basis and manner	of examina	wledge, deat	h occurred at the ti	me, date and pla opinion, death oc	ce, and due to th	e cause(s) a	and manner as	stated.
	Tott Vithii Tott Comp	Me	29b. Signature and title of certifier				29c. Licens			29d. Date	signed (Month,	Day, Year)
			my m,	mo			0.0	.M.E		MARG	CH 16,	2006

State Registrar

MAR 2 0 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 PENN

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

111 PENN STREET, BALTIMORE, MARYLAND 21201

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No., UU h Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 4:55 PM Physician 2006 Duncan Lewis Adams, Jr. Z /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ballimore City Baltimore Sinai Hospital of 6. Sex If Under 1 Year If Under 2 Hrs. 8. Date of Birth (Month, Day, Year) 04/15/1929 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 GM 2□ F Months 76 Maryland 217-24-4518 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County r than "natural", or items 23a or 28a-f ehow the Medical Example: must be invitilled at 1 ☐ Yes 2 ☑ No Baltimore MD Gwynn Oak Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1409 Dorchester Ave. 21207 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\overline{X}\)Yes 2 \(\overline{\overline{\overline{X}}}\) No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) marked other than College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. Foreman Coca-Cola 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 12 should be find and Mental H Duncan Lewis Adams, Sr. Susan Anne Cox 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) t of Health and the triber of Ida Louise Adams / Wife 1409 Dorchester Ave., Gwynn Oak, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of H
Important: If Ite
eny Injury or ot
ance. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park, 03/17/2006 Elkridge, MD 21. Signature of Funeral Price Licensee 22. Name and Address of Facility Cary L. Kaufinan Funeral Home at Meadowridge Memorial Park, IN. 7250 Washington Blvd., Elkridge, MD 21075 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hoomerral 3 days **Physician** /Medical as a consequence of) Myocardio Examiner days arch Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ettending physicien and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the e 9□ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Melletus Diabetes 1 Yes 2 No 3 Probably 4 Manknown certificate has been si rector, page 2 should Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ Mo 24a. Was an ARTERY DISEASE CORONARY 2 No 1 Yes : After this certifical funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 ☑Natural Certification: Division Injury 5 Pending investigation if or Attendin efter death. I Director: Aff d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours eff To the Funerel D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MARCH 13, 2006 RES-000 arrish 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE OF ARORA MANISH HAVIS HOSPITAL 31. Date filed (Month, Day, Year) MAR 2 0 Registrar's Signature State 2006 Registrar

215-0036

2

Maryland

Baltimore,

P.0.

Records.

of Vital

Rower

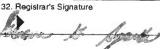
07

State Registrar

DHMH 17 Rev 1/2001

MAR 2 0 2006

31. Date filed (Month, Day, Year)



of death (Item 23a) (Type, Print)

OPIGINIA

O.C.M.E.

111 Penn Street, Baltimore, Maryland

March 17, 2006

21201

State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Robert Gene 15, March 1:30 P 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harkord 422 Haslett Road Joppa 8. Date of Birth (Month, Day, Year) Aug. 25, 1931 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Days Hours 356-22-1677 74 Kentucky Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r then "natural", or items 23s or 28e-f ehow The Madical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Harkord Joppa 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 422 Haslett Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 X Yes 2 No. If Yes, Give K Onean Year or Dates: Conflict 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) 12th Grade Accountant Insurance Pages 1 and 2 should be filed without of Health and Menial Hygier tant: If item 27 is marked other thury or other treumatic event, In marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edith Raymond Bruce Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Janet Bruce 422 Haslett Road, Joppa, MD (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If eny Injury or once. Bel Air Mem'l Gardens 3/20/2006 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes Der 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) **Physician** Coronary /Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-transit inhetes Due to (or as a consequence of) P.O. Box 68760. Completed by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy o in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s certificate has autopsy 1 Yes 2 No 25. Was case referred to medical examiner? Director: After this certification by the funeral director. Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No deat 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 | Homicide within 24 hours aft To the Funarel Di completely filled in To the Hospitel 1 Accretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 2006 Name and address of person who completed cause of death (Item 23a) (Type, Print) 104 Phrutree no bert Be/ 21015 Ste 102 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 2 0 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Amend Item #19b Per FH g853egif29406f Jaleath Reg. No. U U O 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2006 HOMAS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** pi tal Bally More HUS If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex **Funeral** Year Months Hours Min 214-26-3788 Usual Residence of Decedent 1 💢 M 2 🗆 F Yrs. Director 10a. State 10b. County 10c. City, Town or Location Brown, Thoma of Health and Mental Hygiene.
Item 27 is marked other than "nature!", or Items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at BALTIMORE Funeral Director MARYLAND WOOD 10g. Citizen of What Country? 10e. Street and Number 2121 WINDSORGARDEN LANE 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Yes 2 🔼 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ZNo Specify: Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SERVICE SUPERVISOR GRADE ENVIRONMENTAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be THOMAS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or J. wn, Stree, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2121 WINDSOR GARDEN LA THELMA Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. L. cation - City or Town, State 20a. Method of Disposition permit. Pages
Department of t
Important: If Ite
any injury or of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State KINGMEM, PARKCEME 13-20-06 WOODLAWN, 4 □Donation 5 □Other (Specify) BROWN JR, FUNERAL HOME ILTON AVE, BALTO, MD. 21217 21. Signature of Funeral Service Lices 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. HEART ongestive Immediate Cause (Final disease or condition resulting in death) Physician /Medical Renal Disease Examiner TAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and Due to (or as a consequence of) .O. Box 68760, attending physicien for use as the buria Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 I Unknown Division of Vital Records, P. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PERTENSION 3 Probably 4 Winknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2200 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XN0 2 NER/Outpatient 3 □ DOA 유 1 🗌 Yes this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28c. Injury at Work? 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 00054558 1451CIAN 17 cause of death (Item 23a) (Type, Print) Belvedere Ave Baltmore, mn 21215 2401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

10d. Inside City Limits

Approximate Interval Between Onset and Death

Dav

Year

1 Yes 2 No

10:14AM

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

			For	State of M	laryland / Depa	artment of	Health a	and Menta		1116	08303
_			State Registrar		Ce	rtificate of	Death		Reg. No	900	10 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5
	Physicia	n	Decedent's Name (First, Middle,					2. Date Mor	of Death oth Da		3. Time of Death
	/Medic		Frederick Wil			# 03 T		Mar		2006 :. County of Dea	5:45 P ^M
	Examin	er	4a. Facility Name (If not institution,		7	4b. City, Town,					
			337 Sullivan 5. Social Security Number		ge (In yrs. last birthday)	Westm If Under 1 Year	inste	24 Hrs. 8. Date	of Birth oth, Day, Year)	rroll.	rthplace (State or Foreign
н	Funeral Director		213-24-8173	1 ½ □M 2□F	77 Yrs.	Months Days		Min. (Mor	nth, Day, Year) 9 / 1 9 2 8		yland
			Usual Residence of Decedent					-0/-	3/1320		
	yland		10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits
	B Ma	ctol	FL Citru	S	Beverly						1 ☐ Yes 2XDKNo
	ith th	Director	10e. Street and Number		-	10f. Zip Code			10g. Ci	tizen of What C	country?
	ath w		3635 N.Honeyl	ocust Dr.		34465	NP 1- Ori	-:-2 (C#-V-	Uni	ted St	ates erican Indian,
	er de	nne	11. Marital Status	12. Was Deceder Armed Forces		Was Decedent of If Yes, specify Cu	ban, Mexicai	n, Puerto Rican, e	etc.)	Black, Whi	
36	rs aft	by Funerai	1 ☐ Never Married	If Yes, Give Year or Dates	¹Nº 1952-	1 ☐ Yes 2☐XN	o Specify:			Specify:	White
21215-0036	within 72 hours after death, with the Maryland ene. than "natural", or itams 23e or 28e-f show the Marical Exeminer must be notified at		15. Decedent	s Education	1955	dent's Usual Occi	upation		16b. H	Kind of Business	s/Industry
15	in 72	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-40	life.	kind of work don DO NOT use retir	e auring mos red)	st of working	. 1		
212	d with giene.	E O	Cionomary/Socordary (o 12)	1		ter Se	rvice	s Manac		lied S	ignal
	be filed ital Hygie id other avant, II	Bec	17. Father's Name (First, Middle, L	ast)	compe	icci bc.	18. Moth	er's Name (First,	Middle, Maidei	n Sumame)	
/lai	should be ind Mental s marked o		Charles Thurm	an Ruroes	S		Lyda	Anna I	Celly		
Maryland	2 sh and Is m		19a. Informant's Name/Relationsh								Zip Code 34465
	and and male male male male male male male male		Dolores Burge	ss (wife)	20b. Place of Disp	N. Hot	neylo	cust Dr	Bev	erly H	lills, FL
Ore	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition Y☐YBurial 2 ☐ Cremation	3 □Removal from Stat	cemetery, cre	matory of other p	iace)				
Baltimore,	nit. Partmen ortant: injury		' 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L		Lake Vie	W MeIII			006 Sy	Kesvil	ite, MD
Bal	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.			11 /1	7.5		^		al Hom	e & Cr	ematory
		-	23a. Part1. Enter the disease, of shock, or heart failure. List of	complications that caus	ed the death. Do not en	12 W. (Old L	iberty cardiac or respir	Rd Warrest, W	infiel	App MD at 2178
			shock, or heart failure. List of Immediate Cause (Final	only one cause on each	line.	0 1	10101	214 4			Onset and Death
	Priysician /Medical		disease or condition resulting in death)	- O	AST ATIC		RCIN				smonth
п	Examiner			REI	VAL CE	ELL (AR	CINON	14		3 am contin
	100	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	as a consequence of):						
	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the bunat-transit	Examiner	Cause (Disease or injury that initiated events	c							
oʻ	e exe ian ai urial-t	Ex	resulting in death) Last	Due to (or a	as a consequence of):						
3760,	ate be hysici	lical		d							
89 >	certificat nding phy use as th	Mec	IF FEMALE:	02a Kura autaan				·		201 0-1-11	
Box	ath co	ian/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregnar □ Other (specify)				23d. Date of de Month	Day Year
0	the s	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		□ Otilei (specily)					
<u>α</u>	requires that the death seen signed by the atter hould be detached for u	by Physician/Med	Part II. Other significant condition	ns contributing to death	but not resulting in the	underlying cause	given in Part	I. 23	e. Did tobacco	use contribute	to the cause of death?
ds.	uires sign								1 ☐ Yes 2	2 10 46 3□F	Probably 4 Unknown
Records,	w req	Completed						24	a. Was an	24b. Were a	autopsy findings available completion of cause of
Re	The la ate has page 2	mo						10	autopsy performed? Yes 2 1	death?	_
Vital	stcian: The law certificate has b irector, page 2 s	0	25. Was case referred to medical				26. Plac	e of Death (Chec			
>	> 5 b	To B	examiner? 1 Tes 2 No	Hospital: 1 ☐ Inpa	atient 2 ER/Outpatie	ent 3 DOA	Other: 4 N	ursing Home 5	esidence	6 □Other (Sp	pecify)
0	Jing Ph J. After th funeral		27. Manner of Death	28a. Date of li (Month, i	njury 28b. Time Day Year) Injury	W			escribe how inj	ury occurred	
Sio	Attending r death. actor: After by the fune	cati	2 Accident investig	ation			☐Yes 2☐				Over Oracle Morehan
Division of	or Att	Certification:	4 Homicide determ	ned 286. Place of	Injury - At home, farm, s etc. (Specify)	treet, factory, offic	28	Cit	y or Town, Sta	te)	Rural Route Number,
	lospital t hours a unaral C	Ce	29a. Certifier 1 Certifyin	a Physician: To the he	st of my knowledge, dea	ith occurred at the	time date a	nd place, and due	e to the cause(s) and manner	as stated.
	T 4 T 0	ledical	(Check only 2 Medical one)	Examiner: On the basis and manner	of examination and/or	nvestigation, in m	y opinion, de	ath occurred at th	ne time, date a	nd place, and du	ue to the cause(s)
	To the within 2 To the complet	Me	29b. Single and title of certified			29c. Lice	ense number			ate signed (Moi	
	C>F0		Chilquide	Neceture		DI	8300		3	3113106	7
. 1	1 101		30. Name and address of person	who completed cause of	of death (Item 23a) (Type	e, Print)		+	e de calair.		
10	' /		CHITRACHEDY ,	VACANNA M.		fore ?	d'a	estanius	e MI	1 2113	7.
	St		31. Date filed (Month, Day, Year)		strar's Signature	ande?					
	Regist	ar	MAR 2 0	LUUD DOG	10 1 17						

			Please	State of Ma									egible.		
		•	For State	State Of Ivid	ai ytai iu				Death	aria ivi		Reg. No.	106	0830	14
	4		Registrar 1. Decedent's Name (First, Middle, Last)			imout	0 0, 2	-		2. Date of Dea	ath	2 12 13	3. Time of D	Death
	Physicia		Amelia Barbara	Baldwin							March	$1^{ extsf{Day}}_{6}$	2006	6:57	Ам
	/Medic Examin	40	4a. Fecility Name (If not institution, give				4b. City,	Town, or	Location o	f Death		4c. Co	ounty of Death		
	- Admin	il.	Stella Maris				Tir	noniu	ım			В	altimor		
	Funeral		Social Security Number 6. Se	x 7. Age □M 2 X F	e (In yrs. las		If Unde Months	r 1 Year Days	If Under	24 Hrs. Min.	8. Date of Birt (Month, Day	y, Year)	9. Birthp	lace (State or htry)	Foreign
	Director		213-32-9929 Usual Residence of Decedent		97	Yrs.					June 28	, 190	8 Mar	ryland	
land	* =		10a. State 10b. County		10c. City,	Town or Lo	cation			-			1	0d. Inside City	y Limits
Mary	등등	to	Maryland Baltimo	re	T	imoni	um							1 ☐ Yes	2 X No
h the	r 28a	irec	10e. Street and Number					Code				10g. Citize	n of What Cour	ntry?	
th wit	23a c	Funeral Director	2300 Dulaney Valle	ey Rd.				L093					ted Sta		
r dea	E 3	nuel	11. Marital Status	12. Was Decedent Armed Forces?		. 13.	Was Dece If Yes, spe	dent of Hi orify Cuba	spanic Ori n, Mexican	gin? (Sp ı, Puerto	ecify Yes or No Rican, etc.)	- 14	. Race - Americ Black, White,		
s afte	, a	by F	1 Never Married 2 Married 3 XWidowed 4 Divorced	1 ☐ Yes 2 XXIII If Yes, Give Year or Dates:	No.		1 🗌 Yes	2 X No	Specify:			s	pecify: wh	ite	
2-000 72 hours after death with the Maryland	atura Cal E	edit	15. Decedent's Ed	ucation	-	16a. Deced	dent's Usu	al Occupa	ation			16b. Kind	of Business/In		
6 10 7	New In	Completed	(Specify only highest grad	de completed) College (1-4or 5	5+)	life.	DO NOT L	ise retired			ing	-	/	1	
d wit	giene er th	DO.	10			sa1	es r	epres	senta				thing/r	etail	
yld be file	d oth	Be	17. Father's Name (First, Middle, Last)							rs Name Rau	e (First, Middle, Ch	Maiden S	umame)		
	r Men narke natic	ျှ	George Wiegard	Original Control		10h Mailie	na Addres	a /Stroot			al Route Numbe	or City or 1	Town State Zir	Codel	
Value of the set of th	T is not 7 is not traulh		19a. Informant's Name/Relationship (7) Dorsey N. Baldwin			16 Ma	•					1204	own, olato, e.p.	, 0040,	
ָה בַּ	Heat tem 2 other		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Na	me of	1		Date		tion - City or To	own, State	
	Department of Health and Mental Hygiene. Important: or Items 23s or 28s-f show Important: If Item 27 is marked other then "natural; or Items 23s or 28s-f show any injury or other traumatic event, Ite Mudical Examiner must be notified at 80ce.		1 ☐ Burial 2 XX Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify							ar.1	8,2006	Balt:	imore,	Marylar	nd
ALLIMOT TMIT Pages	partm Sortal	1	21. Signature of Funeral Service Licen		10200										
Ď 8	Depa Impo		Jefn O. Mi	tchell			6	500	York"	Rd.	feld Fu Balti	more,	MD 21	212	
			23a. Part1. Enter the disease, or composhock, or heart failure. List only	olications that caused one cause on each li						cardia	or respiratory a	rrest,		Approximate Interval Betw Onset and D	veen
	nysician		Immediate Cause (Final disease or condition	a	EN	6 42/	1155		11	10/2	1105	- 150	6005	Onset and D	, odu i
	/Medical xaminer		resulting in death)	Due to (or as	a conseque	ence of):									
4	(See	<u>_</u>	Sequentially list conditions,	b. Due to (or as	a conseque	ence of):			_						
ted.	usit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			,									
bU, be executed	n and ial-tra	Exal	that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):									
/60 1	attending physician and for use as the burial-transit	cal	(d											
diffical car	ng ph	Physician/Medi	IF FEMALE:												
מסא מסא	ttendi or use	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fetal	death 3[□Ectopic _I		,			23	Id. Date of deliv Month		/ear
	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∏Pregnant a 9∏Unknown	t time of dea	ath 5L	Other (s	греспу)							
<u> </u>	igned by the a	-P	Part II. Other significant conditions of	ontributing to death b	out pet resul	Iting in the 0	inderlying	cause giv	en in Part I	1.	23e. Did t	obacco us	e contribute to	the cause of de	eath?
ecords,	ed bl	d by	Ender 1100	1200		1 = 1 /					10	Yes 2	No 3 ☐ Pro	bably 4	loknown
	as been si 2 should b	Completed	Sige willed	ghr se	20						24a. Was		24b. Were aut	opsy findings a	available
e f	te ha	mo	Wenistic								auto perfo	ormed?	death?		1036 01
		BeC	25. Was case referred to medical		- Alle	1808			26. Place	e of Deat	th Check only	one)			
	nis ce I direc	To	examiner?	Hospital: 1 Inpati	ent 2 E	R/Outpatie	nt 3 🗆 C			ursing Ho	ome 5 ☐ Resi			(ty)	
0 2	leath. tor: Atter this certificate ha the funeral director, page 2		27 Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	ay Yeer)	28b. Time o Injury		28c. Injur Wor		101-	28d. Describe	how injury	occurred		
VISION OF VITA	death.	cati	2 Accident investigation 3 Suicide 6 Could not be		ium. At hor	mo farm of	M facts		Yes 2	JNO	28f Location /	Street and	Number or Rui	al Route Numi	ber.
= 2	atter death Director:	Certification:	4 Homicide determined	28e. Place of In building, e	tc. (Specify,))	. col, iacic	ry, onice				wn, State)			
Tation Charles	within 24 hours after d To the Funeral Direct completely tilled in by		29a. Certifier	ysicien: To the best	t of my know	vledge, dea	th occurre	d at the tir	me, date a	nd place,	and due to the	cause(s) a	ind manner as	stated.	
3	n 24 h	edical	(Check only 2 Medical Exer	niner: On the basis of and manner st	of examinati	ion and/or ir	nvestigatio	n, in my c	pinion, dea	ath occur	red at the time,	date and p	place, and due	to the cause(s))
, F	withir To th	Me	29b. Signature and title of certifier	6.	po	2	2	9c. Licens	number		04	29d. Date	signed (Month	, Day, Year)	
ì	3) / Car	2007 6				-	13			3/	101/6		
	b		30. Name and address of person who		death (Item			T.T.FV	ROZT)	TIMONIU	IM MI	210	93	
g	1-1-		EDDIE NAKHUDA, 31. Date filed (Month, Day, Year)	M.D.			u⊥ V.F.		TOAL						
	St Regist	ate	MAR 2 0 2006	Allen a	M	Casa	E.								

6:57 A.M.

MARCH 16, 2006

BALDWIN, AMELIA

Κ.,	S ONY COI	NW.		se Type or State		nt in Bla aryland /						7		_	ble.		
			1 - State Registrar				Cei	tificate	of [Death			Reg. N	200	16_	083	05
	Physici	an	Decedent's Name (First, Midd. Anthony	le, Last)	E-11	aono			Con			2. Date of D Month	D	,	Year	3. Time of E	
}	/Medic Examin		4a. Facility Name (If not institution JOHNS HOPKIN	n, give street and no S HOSPITA	ımber)	gene		4b. City, T	Town, or	away Location (IORE	of Death	MARC		200 c. County		1905	Р
	Funeral Director		5. Social Security Number 215-96-7303	6. Sex 1 💥 M 2 🗆 F		e (In yrs. last	birthday) Yrs.	If Under		If Under Hours		8. Date of B (Month, D	ay, Year	55	9. Birth	place (State or intry) M.D.	Foreign
	D D		Usual Residence of Decedent									00 1	/				
	death with the Maryland ms 23a or 28a-f ehow	ō	10a. State 10b. County			10c. City, To										10d. Inside City X□ Yes	
	r 28a-	Funeral Director	MD NA 10e. Street and Number			Rai	timo	10f. Zip	Code				10g. C	itizen of V	Vhat Cou	intry?	
	ath will	ralD	4007 Ayrdale						212					U.	S.A	•	
	ltems Items	nue	11. Marital Status X Never Married 2 Mar	12. Was De	orces?		13. \	Nas Decede f Yes, speci	ent of His rfy Cubar	spanic Ori n, Mexicar	igin? (Sp n, Puerto	ecify Yes or N Rican, etc.)	lo-		e - Ameri k, White	ican Indian, , etc.	
2000	s 1 and 2 should be filed within 72 hours after death with the Marylan f Heelint and Memial Hygiene. If Heelint and Memial Hygiene a fatturel, or Items 23a or 28a-f show other traumatic event, the Modical Exaction must be notified at	by	3 Widowed 4 Divorced	If Yes. G	ive	10		1□Yes 2	No.	Specify:				Specify	:]	Black	
ה ה	"natur	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)	1	6a. Deced	lent's Usual kind of worl DO NOT use	l Occupa k done d	tion uring mos	st of work	ing	16b. I	Kind of Bu	isiness/îr	ndustry	
7	1 within 72 pene. r then "na!	d mo	Elementary/Secondary (0-12)	College na	(1-4or 5	5+)		nemp	_	_				Une	mpl	oyed	
	be filed ital Hygirid other event, II	BeC	17. Father's Name (First, Middle,							18. Mothe	er's Nam	e (First, Middl	e, Maide	n Sumam	e)		
2	should bind Menting Marked	2	William Cona									Daley	P				
_	d 2 sho th and 7 iem traum		19a. Informant's Name/Relations					100000				al Route Num					
D)	Heelth Heelth tem 27 other tr		Doretha Cona 20a. Method of Disposition	way-Moti	ier	20b. Place	of Dispo	sition (Nam	e of	1		B alti : Date	7			21215 own, State	
Ē	Pages nent of nt: if i		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 Removal from Specify)	State	[natory`or oti 10 ri .a			3/2	1/06	Ra	nda.	llst	town,	Md
altimo	permit. Pages Depertment of h important: if its eny injury or of once.		21. Signature of Funeral Service		W	10.11		. Name and									
) F	Physician /Medical Examiner		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. MUC Due to	TIPU (or as	E SH	ARP ce of):	er the mode	of dying	, such as	cardiac			e,	Md	21215 Approximate Interval Betw Onset and De	reen
	ate be executed hysicien and the burial-transit	dical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Ś		a consequent											
O. DOX 0	To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 burus efter death certificate be exwithin 24 burus efter death. To the Funerie Director: After this certificate has been signed by the attending physicien completely filled in by the funeral director, page 2 should be detached for use as the buria	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	birth nant at	of pregnancy 2 Fetal death time of death	ath 3 □	Ectopic pre						23d. Date Mor		-	ear
cords, P	luires thet n signed b uld be deta	þ	Part II. Other significant conditi	ons contributing to	death b	ut not resultin	g in the ur	nderlying ca	iuse give	n in Part I	l.		tobacco			the cause of de	
	The law receive the law received has been page 2 short	Completed						· · · · · · · · · · · · · · · · · · ·				24a. Wa aut per 1 X Yes	opsy formed?	d	leath?	opsy findings avompletion of cau	variable use of
VICA	sician certifi rector	Be	25. Was case referred to medica examiner?	Hospital:					Othe	_		h (Check only					
5	p Phys ar this aral di	n; To	1 Yes 2 No 27. Manner of Death	28a. Date	Inpatie of Inju	rv 281	b. Time of	t 3 DO	A Bc. Injury Work	4 🗆 140		me 5 Res 28d. Describe	how inju	ury occurr	ed	,,	
	ath. ath. r: Afte	atlo		igation 03/	oth, Day 2/0	6 7:	Injury 23 P	М		? 'es 2.	No	SUBTECT	ASSA	VLTE0	TIW (H SAARF	06TEC1
	l or Atte efter de Directo J in by th	Certification;	3 ☐ Suicide 6 ☐ Could Homicide determ	nined 289. Place	ding, etc	ury - At home c. (Specify)	farm, str	21	office			28f. Location City or To 4015 E	own, Stai	te)		al Route Numb	oer,
	or the Hospital or Attending Physician: within 24 hours eller death selector. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier 1 Certifyir (Check only 2 Medical	ng Physician: To the Examinar: On the and ma	e best	of my knowled f examination	dge, death	occurred a	at the tim in my op	e, date ar inion, dea	nd place,	and due to the	e cause(s) and ma	nner as	stated.	
	ro the within ro the	Me	29b. Signature and title of certific			160.		29c.	License	number			29d. D	ate signed	i (Month,	Day, Year)	
)	10		Duas.	,					0.0	.M.E			MA	RCH	15,	2006	
0	2		30. Name and address of person	10 , M	0	111	PEN		EET,	BALI	CIMOI	RE,MARY	LANI	212	01		
ı	Sta Registr		31. Date filed (Month, Day, Year, MAR 2	0 2006 32.	gistr	ar's Signatur		series	,								

			State	State of Maryland		rtment of			giene Reg. No. 11 11 1	5 08306
			Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
	Physicia	an	John Anthony	Crilley				March	14 200 d	3:30p ^M
	/Medic Examin		4a. Facility Name (If not institution, give str			4b. City, Town	n, or Location of De	eath	4c. County of	
	Lxamiii	-	Franklin Woods I	Nursing Cen	ter	Rose			Balti	
-	Funeral	- 1	5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Ye Months Day		8. Date of Bird (Month, Da Jan. 1	h y, Year)	Birthplace (State or Foreign Country)
١.,	Director		217-14-3214	^{1 2□ F} 88	Yrs.			Jan.I,	1918	PA
	pus *		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Maryli feho	JO.	MD Baltimo	re Ro	seda!	le				1 ☐ Yes 2€ No
	the the	Director	10e. Street and Number			10f. Zip Cod	ө		10g. Citizen of Wh	nat Country?
	3a or	Ö	8917 May Flowe	r Road		212	37		USA	
	within 72 hours after death with the Maryland ene. than "natural", or feme 23a or 28a-f ehow than "Medical Examinar must be collifiad at	Funerai	11. Marital Status	. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent	of Hispanic Origin? Juban, Mexican, Pu	(Specify Yes or No Jerto Rican, etc.)		- American Indian, , White, etc.
9	after or Ite	교	1 Never Married 2 Married	1. Yes 2 □ No If Yes, Give		1☐ Yes 2☑X	No Specify:		Specify:	White
21215-0036	ural',	d by	3X Widowed 4 □ Divorced	Year or Dates:	16a Doces	ient's Usual Oc	cupation		16b. Kind of Bus	
7	n 72 i	iete	15. Decedent's Educa (Specify only highest grade	completed)	(Give	kind of work do	ne during most of tired)	working		ore County
2	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Mecha	anic			Darcinc	ore country
0	filed with Hygiene. other ther	a	17. Father's Name (First, Middle, Last)					Name (First, Middle,)
lan	should be and Mental I is marked o	To B	John Joseph Cr	illey				abeth Cı		
Maryland			19a. Informant's Name/Relationship (Type					Rural Route Numb		
	1 and 2 Health tem 27 other tra		Margaret Ketche			/ May sition (Name o		Road Bal		City or Town, State
Baltimore,	ges 1 a t of Hea lf item or othe		20a. Method of Disposition № Burial 2 ☐ Cremation 3 ☐ Re	movai from State Hol	netery, crer	illi Ce	metery	3/17/06	Baltime	ore MD
ţ	tmen tant:		*4 □Donation 5 □Other (Specify)		-					
Bal	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service License	000				300 Mace		
			23a. Part1. Enter the disease, or contents shock, or heart failure. List only one	ations that caused the death.	Do not ent	er the mode of	dying, such as car	diac or respiratory a	rrest,	Approximate Interval Between
	Dhusisian		Immediate Cause (Final	cause on each line.	س دیا	24 01	N 1 1 1 1 1 1	AA CTI	- ~ 1	Onset and Death
	Physician / Medical		disease or condition resulting in death)	Due to (or as a conseque	ence of):	11/2 6/1	m C 1741	11000000	7 7 9	
и	Examiner		Conversion to the first good livings	CURUNIAN	Y A	KICK	4 DID 1	CASE		
н	n ≓	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):					
	ecute and trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a conseque	ence of):					
8760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit			540 10 (0) 40 4 00,1004	3.100 01).					
287	physicate sthe	Physician/Medicai	d.							
9 X	leath certifica attending ph i for use as th	/Me	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregnan		ne			23d. Date	of delivery
Вох	Jeath atter	ciar	in the past 12 months?	1☐Live birth 2☐Fetal 4☐Pregnant at time of de		□Ectopic preg <i>n</i> □ Other (s <i>pecif</i>			Mon	th Day Year
P.O.	that the de ed by the detached	hysi	9 Unknown	9□ Unknown						
	res tha igned l	by P	Part II. Other significant conditions conf		ting in the u	inderlying caus	e given in Part I.			ibute to the cause of death? 3 Probably 4 Unknown
ğ	w require been sig should t	led	DEMONTI	A		· · · · · · · · · · · · · · · · · · ·		_		5 Frobably 4 Dolknown
Records,	e law re has be ge 2 sh	Completed						24a. Was	psv p	Vere autopsy findings available rior to completion of cause of leath?
H	The ate h page	Sol						1 ☐ Yes		Yes 2 No
Vital	ician: The certificate ector, pag	Be	25. Was case referred to medical examiner?	ospital:			Othor	Death Check onl		
d	Physic this c	ဥ	1 Yes 2 ≱NO	1 Inpatient 2 t	R/Outpatie		4 Mursi	ng Home 5 ☐ Res 28d. Describe	how injury occurre	
Su C	ding Physician: The h. h. After this certificate h. funeral director, page	lon	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	м	Injury at Work? 1 ☐ Yes 2 ☐ No			
Division	Attending Physician: r death. ector: After this certifics by the funeral director, I	lical	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At ho	me, farm, st	reet, factory, of	ffice		(Street and Number	er or Rural Route Number,
Ω̈́	after after Dire	Certification:	4 Homicide	building, etc. (Specify)			City of To	own, State)	
	To the Hospitel or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Phys	ician: To the best of my knowner: On the basis of examinat	vledge, dea	th occurred at t	he time, date and p	place, and due to the	cause(s) and ma	nner as stated.
	the Ho hin 24 the Fu	edical	one)	and manner stated.	on and or n					
	To the vithing to the total	Σ	29b. Signature and title of certifier				icense number		0	(Month, Day, Year)
•	0		n V	^/)			47945		MANCE	15 2006
	100		30. Name and address of person who co	- 35.5	23a) (Type			WSON	140 0	1204
			31. Date filed (Month, Day, Year)	32. Begistrar's Signar		1 11/1	0 - 10	00-070		r w F
	Penis	tate	MAR 2 0 201		W A	Cart of				

		1 Registrar				Ce	rtificate	e or D	eatn	1 - :	Reg.:	No.	Ub (11
hysicia		1. Decedent's Nar	1, 1	COMP						2. Date Mon		Day	Year Zwb	3. Time of 804	Death
/Medica :xamine	-	4a. Facility Name Howard C	(If not institution,	give street and no			1	Town, or L	ocation of Dea				inty of Death		
neral ector		5. Social Security 215-36-4	:009	5. Sex 1	7. Age (In yrs 66	. last birthday) Yrs.	If Under Months		If Under 24 Hr Hours Mir	8. Date (Mon 03/	of Birth th, <i>Day</i> , Ye 27/19:	39	9. Birthpl Count Washi	ace (State of Iny) ngton	r Fore
ie a at	tor	Usual Residence 10a. State MD	10b. County Howard			ity, Town or Lo umbia	ocation						10	0d. Inside Ci 1 X Yes	
Strenoti	ai Direc	10e. Street and N 5784 Yel	umber lowrose	CT.			10f. Zip	21045			10g.	Citizen	of What Coun USA	try?	
importent: if item 27 is marked other than "natural, or items 23s or 28s-1 show any injury or other treumatic event, the Medical Examinar must be notified at once.	Completed by Funeral Director		rtied 2 X Married 4 □ Divorced	Armed F	2 □ No Sive		Was Deced If Yes, spec		oanic Origin? (Mexican, Pue Specify:	Specify Yes no Rican, et	or No- c.)	В	Race - America Black, White, e ecify:White	etc.	
Medical	npieted	(Spe	15. Decedent's acify only highest condary (0-12)	grade completed College	(1-4or 5+)	(Give		ork done du se retired)	ring most of w	orking			f Business/Ind	•	
c event, the	To Be Cor	17. Father's Name Frederic			5+	rogr	am An	1	S 8. Mother's Na Rosalie		fiddle, Maid	den Sum	Security name)	y Admir	•
s 27 is mari er treumati	-	19a. Informant's ? Carole C	Name/Relationship				_		d Number or F			-		Code)	
ant: If item ary or oth			sposition Cremation 3 5 Other (Spe		n State	Place of Dispo cemetery, cre- cowridge	matory`or o	other place)	k 03/	Date 17/200			on - City or Ton		
i ii		21. Signature of F	uneral Service Lie	censee	1	_ 2:	2. Name an	nd Address	of Facility	I Ioma -			by Memor		
sician edical) Cu	ion	omplications that not one cause on a.	caused the dea each line.	ath. Do not en	ter the mode	de of dying,	such as cardia	ic or respira	tory arrest.	.073		Approximat Interval Bet	e weer
oysician and sicial reassit and burial-transit and	icai Ex	23a. Part1. Ent reshock, or per limmediate Cause disease or condit	(Final on onditions, mmediate lerlying r injury ts	a. Due to	er faile	ath. Do not en	ter the mode	de of dying,	such as cardia	ic or respira	tory arrest.	.073		Approximat Interval Bet	e weer
g physician and as the burial-transit as the burial-transit	icai Ex	23a. Part1. Enture shock, or policy shock, or policy shock, or policy shock and the shock of the	onditions, mmediate lerlying t injury ts Last nt pregnant 2 months?	a. Live b. Due to d. 23c. If yes, or	o (or as a consecution of oregrant at time of	atth. Do not en Lie Section quence of): quence of): quence of): annoy al death 3[ter the mode	de of dying,	such as cardia	ic or respira	tory arrest.	1yn	Date of deliver	Approximat Interval Bet Onset and I	e ween
igned by the attending physician and properties as the burial-transit	by Physician/Medical Ex	23a. Part1. Enture shock, or of limmediate Cause disease or condit resulting in death Sequentially list of any, leading to cause. Enter Uncause (Disease othat initiated even resulting in death) IF FEMALE: 23b. Was deceded in the past 1. 1 Ves 2	onditions, mmediate lerlying r injury is Last	a. Due to d	o (or as a consecution of pregration of pregrant at time of nown	ath. Do not en Like Sector quence of): quence of): quence of): annoy al death 35 death 55	Ter the mode	de of dying,	large	ac or respira	B CC 1	1yn	Date of deliver	Approximatinterval Bet Onset and I	e ween Death
ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical Ex	23a. Part1. Enturshock, or personal shock, or perso	onditions, mmediate lerlying r injury is Last	a. Due to d	o (or as a consecution of pregration of pregrant at time of nown	ath. Do not en Like Sector quence of): quence of): quence of): annoy al death 35 death 55	Ter the mode	de of dying,	large	23e	B CC	23d. I	Date of delivered Month on thouse to the orange of the ora	Approximate Interval Bet Onset and I	e ween Death
Affer this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical Ex	23a. Part1. Enture shock, or personal shock, or per	onditions, medical	omplications that nly one cause on a	o (or as a consecuted or as a co	ath. Do not en Like Sector quence of): quence of): quence of): anancy al death 35 death 55	DAY DEctopic prince of the control	regnancy pecify) Cause given Cause given Cause given Cause given	in Part I.	23e 24a 1□ ath (Check	Did tobacc	23d. I	Date of delivered Month ontribute to the condeath? 1 Yes	Approximate Interval Bet Onset and I was a conset a	e ween Death
Affer this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical Ex	23a. Part1. Enturshock, or policy shock,	onditions, medical on on onditions, medicate learlying injury ts. Last on on on one of the one of t	omplications that any one cause on a. Due to b. Due to c. Due to d. 23c. If yes, on 1 Live 4 Preg 9 Unkers to contributing to the contribution to be 28e. Placeton 1 1 28a. Date to contribution to be 28e. Placeton 2 28e. Placeton 2	o (or as a consecution of or as a consecution of pregramma at time of nown death but not respond to the consecution of the cons	quence of): quence of): quence of): quence of): quence of): pancy al death 3[death 5[action of the unit of	DEctopic production of the results o	regnancy pecify) DA Other: 28c. Injury a Work? 1 Ye	in Part I.	23e 24a 1 □ 28d. Des	Did tobacc I Yes Was an autopsy eleptory appropriate years What are autopsy eleptory eleptory eleptory eleptory elect	23d. I	Date of delivered Month ontribute to the condeath? 1 Yes	Approximate Interval Bet Onset and I was a large of data above a large of the large	e eween Death Will (ear eath)
Affer this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the burial-transit	edical Certification: To Be Completed by Physician/Medical Ex	23a. Part1. Enture shock, or per limited to cause disease or condition of any, leading to cause. Enter Unc. Cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was deceded in the past 1. 1	onditions, minediate leriying in injury is Last at pregnant 2 months? No n ifficant condition orred to medical No ath 5 Pending investiga 6 Could no determin	Due to d	constant time of nown death but not report of Injury and in Day Year)	ath. Do not en Cressor Quence of): quence of): quence of): quence of): quence of): sulting in the unity in the unit	DEctopic production of the sector of the sec	regnancy reg	in Part I.	23e 24a 1	Did tobacc Did tobacc Was an autopsy performed from one) Residence cribe how in the control of the cause o	23d. I	Date of deliver Month ontribute to the state of the state of deliver Month b. Were autopprior to comdeath? death? Other (Specify curred)	Approximate Interval Bet Onset and I onset	e ween no eath Well ween no eath?
In the Funerial Director: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit.	Certification; To Be Completed by Physician/Medical Ex	23a. Part1. Enturshock, or policy in the past 1 and part 1. Sequentially list of any, leading to cause. Enter Unc Cause (Disease of that initiated even resulting in death; IF FEMALE: 23b. Was decede in the past 1 1 Yes 2 9 Unknow Part II. Other sign 25. Was case reference in the past 1 and past 1 and past 1 and past 2 and past 2 and past 3 and past 2 and past 3 and pas	onditions, minediate letrying terrying rinjury ts Last Int pregnant 2 months? No no ifficant condition investiga 6 Could no determine 2 Medical Ex	Due to d	coras a consecution of or as a consecution of	quence of): quence of): quence of): quence of): quence of): quence of): pancy al death 3[death 5[Ectopic production of the course of the cou	regnancy pecify) DA Other. 28c. Injury a Work? 1 Ye y, office at the time at the time License re	in Part I.	23e 24a 1□ ath /Check Home 5□ 28f. Loca City e, and due turred at the	Did tobacc Did tobacc Security Did tobacc United to tobacc Did tobacc Unite	23d. I	Date of deliver Month Date of deliver Month Date of deliver Month Date of deliver Month Date of deliver death? 1 Yes Date of deliver death? The probability of the probability of the month of the probability of the	Approximate Interval Bet Onset and I onset	e e ween no eath well a lear lear lear lear lear lear lear	

Registrar

	2712	For State Registrar	liddle Les		Marylan		artmen rtificat			and M	ental Hyo	leg. No. U	06	083	09
Physicia		Decedent's Name (First, A David	A.	t)	Cunni	ngham					March 18		Year	3:35	Рм
/Medic Examin	-34	4a. Facility Name (If not instit	_						Location of	of Death			inty of Death		
	***	Genesis Elder	care		age Ce			ndal	k If Under	24 Hrs.	8 Date of Birt		altimo		or Foreign
Funeral Director		5. Social Security Number 213-78-9677 Usual Residence of Deceder	12	ØM 2□F	4		Months	Days	Hours	Min.	8. Date of Birth (Month, Day October	24°, 1960	Dove	place (State on Itry) Delay	vare
ryland thow	_	10a. State 10b. Co			10c. Cit	ty, Town or L								10d. Inside C	ity Limits 2 X No
he Ma 28a-1	ecto	Maryland Bal	timo	ce		Dunda	10f. Zip	Code				10a Citizen	of What Cou		-21
is 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygienes. It Health and Mental Hygienes from 1 terms 23a or 28a-f show other treumstic event, the Madical Examinar near the truffied at	Funeral Director	7549 Berkshir	e Roa	ad				224					SA	,	
death	nera	11. Marital Status		12. Was Dece Armed For	dent Ever in U	.S. 13.	Was Deced	dent of Hi	ispanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)	14.	Race - Amer Black, White		
s after	by Fu	1 Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Divo		1 ☐ Yes If Yes, Giv Year or Da	2 X No		1 ☐ Yes		Specify:				^{∍cify:} Whi	te	
turs!	ed b	15. Dec	edent's Ed	lucation	3165.	16a. Dece	dent's Usu	al Occup	ation			16b. Kind o	of Business/li		
thin 72 B. an "nat	Completed	(Specify only h Elementary/Secondary (0-		de completed) College (1	-4or 5+)		kind of wo DO NOT u								
filed wi Hygien other th		12 years 17. Father's Name (First, Mic	idle (act)			In	vento	ry C			erk (First, Middle,		e Depo	t	
ould be fi Mental H warked ot	o Be	Jimmy Keith									Jankow				
2 should and Me ie mark eumatil	Ţ	19a. Informant's Name/Rela		_		19b. Mail			and Numbi	er or Rura	I Route Numbe	r, City or To		p Code)	
s t and 2 of Health a Item 27 is other tre		Dorothy Cunn	nghai	m mo	ther	7549					Dundalk,				
		20a. Method of Disposition 1 ☐ Burial 2 ☑ Crema 4 ☐ Donation 5 ☐ Oth	tion 3 🗆	Removal from	State Dov	Place of Disp cemetery, cre			(e)		n 20,		on - City or T	own, State	
nit. Page Lartment o ortant: If Injury or		4 □Donation ¹ 5 □Oth 21. Signature of Funeral Se		1	bay	view (ss of Facili	2006					
Department of the police		hithor	المال	(, ()	muel	lu	onne 7110 S	lly I solle	uner ers P	ál Ho Sint	ome Of I Road, I	Dunda l Dunda l	k, P. ? k, MD.	21222	
/Medical Examiner	dicai Examiner	23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	List only	ab. Due to (or as a consector as	quence of):	15	6	C	L	IVE	R		Interval Be Onset and	
The law requires that the death certificat ete has been signed by the attending phy page 2 should be detached for use as th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnal in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			oirth 2 ☐ Feta nant at time of	al death 3	□Ectopic p □ Other (s)					23d	. Date of deli Month	very Day	Year
ires that signed b	by PI	Part II. Other significant co	nditions c	ontributing to d	eath but not re	sulting in the	underlying	cause giv	en in Part	l.	23e. Did t			the cause of	
he law requir e has been si age 2 should	eted	TNI	NRI	16	ARI	NF					24a. Was	an 2	4b. Were au	topsy finding:	s available
sicien: The lav certificete has rector, page 2:	Comp	1,0,		0 9	,,,,,	O F					autor		prior to death?	completion of	cause of
Attending Physicien: The death. c death. sector: After this certificete by the funeral director, pag	Be	25. Was case referred to me examiner?	edical	Hospital:	Inpatient 2] ER/Outpatie	ent 3⊡ D	OA Oth	or -	/	h <i>Check only</i> o		Other (See	vhv)	
ding Phyen. After this funeral di	n: To	27. Manne Death		28a. Date		28b. Time Injury		28c. Injur Wor	y at	draing the	28d. Describe				
ttending f death. ctor: After y the funer	atio	2 Accident in	ending vestigation	n		l mary	М		Yes 2]No					
P = 1 = 2	Certification:	3 ☐ Suicide 6 ☐ C 4 ☐ Hornicide	ould not be etermined	288. Place	of Injury - At hing, etc. (Spec	nome, farm, s ify)	treet, factor	ry, office			28f. Location (City or To		lumber or Ru	ral Route Nu	m <i>ber</i> ,
Hospitel 24 hours a Funeral H	Medical			nysicien: To the niner: On the b and man											(s)
To the To the To the Co. phel	₹.	29b. Signatur and itle	ertifier	101	2		29	c. Licens	e number	-		29d. Date s	igned (Monti	n, Day, Year)	- (
) Ilu	Som	tingl	- 1	0		DI	414	0	1	MAR	CH 1	9,20	006
10.		30. Namerand sources of po	orson who	Soulphale Com	se propath (No	m 234 Type	10 P	10-	AR	IT	CHIE	HIG C C	HWH	772	
Sta Regist		31. Date filed (Month, Day,	Year)		rar's Sign	nature	1				()	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Cornell Margaret Irene March 15, 2006 12:36 A /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Dundalk 1921 Maxwell Avenue Baltimore Co. If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 □ F Yrs. Director 217-34-4245 68 Jan. 11,1938 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Items 23s or 28s-f ehow the Medical Examiner must be nutitled at 1XXYes 2 □ No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21222 1921 Maxwell Avenue United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: Completed by ₩Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygle.
Importent: If item 27 is marked other ti
any Injury or other traumatic event, the 10 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary K. McMenamen Eugene F. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10560 Philadelphia Road White Marsh, MD 21162 Mrs. Cathy Miller (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 3/16/2006 Towson, Maryland 21. Signature of Funeral Bervice Licenses Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as sock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due to (or as consequence of):

Due to (or as consequence of):

Due to (or as consequence of): 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Due to (or as a consequence of): physicien Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy sete hes been signed by the atterpage 2 should be detached for a Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by metastatic breast cancer 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Hypertenson 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes or Attending Physician: completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DDA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t 5 Pending within 24 hours after death. To the Funerel Director: A 1 Tes 2 No 2 Accident investigation 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) attansia MD. 0-28097 Konald 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)

A 1111 Obila delphia Road Suite (08; Balt, Md. 21237)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, L

3

Maryland 21215-0036

Baltimore,

o

Records,

Division of Vital

2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day March 15,2006 **Physician** Isabel Elizabeth Cox 7:45 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Rossville Manor Care Rossville Baltimore Co. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🛣 F Yrs. Director 233-30-0551 83 Sept. 2,1922 West Virginia Usual Residence of Decedent the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits itam 27 is markad othar than "natural", or itams 23a or 28a-f show othar traumatic avant, the Medical Examinat must be notified at 1 Yes 2 No Director Fort Howard Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21052 United States 9425 North Point Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: β Specify 3 X Widowed 4 □ Divorced White 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should ba fited withIn 7/ Ih and Mental Hygiene. 7 is markad othar than "n Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nellie Gay Chaddock John Fickisen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If itam 27 is n any injury or othar traun Aberdeen, Maryland 21001 3322 Churchville Road (Daughter) Mrs. Ellen Piker 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. Gdns. 3/17/2006 Timonium, MD ↓ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part Sener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final small cell Physician Concer Non disease or condition resulting in death) /Medical **Examiner** Alexia due Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Oborh mail Due to (or as a consequence of): attending physician for use as the burial Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed 2 - No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 20 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: To tha Hospital or Attanding I within 24 hours after death. To tha Funaral Diractor: After 5 Pending 1 Natural Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certified 29c. License number MID 31464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. ENTAN ST Snik 308 BALTIMORE MD 21201 HARHMI MD 31. Date filed (Month, Day, Year) State Registrar

		1 - State Amend Item Registrar 1. Decedent's Name (First, Middle, Las		verb.	,G853',(tificat	e of L	Death	2. Date of		2006	3. Time of Death
hysici: /Medic		Lannie Harmon	Cavey				•		Month	15 D	2006 Year	1359 M
xamin		4a. Facility Name (If not institution, give Carroll Hospital					Town, or stmin	Location of D Ster	eath	4	c. County of Death Carro11	1
neral ector			x □ M 2 1 F	7. Age (In yrs. 81	last birthday) Yrs.	If Under Months	r 1 Year Days	If Under 24 I Hours N	Hrs. 8. Date of (Month, Sept	Birth Day, Yea 3 19	9. Birth VA.	nplace (State or Foreign untry)
cal Examiner must be notified at	tor	Usual Residence of Decedent 10a. State 10b. County Md Carroll			ty, Town or Lo		.					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Director	10e. Street and Number 1011 Grandview	Avenue			10f. Zip	Code			10g. C	Citizen of What Cou	untry?
	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Yes : If Yes, Give Year or Da	ces? 2X No	1	Was Dece f Yes, spe l □ Yes	cify Cuba	spanic Origin? n, Mexican, Po Specify:	? (Specify Yes or uerto Rican, etc.)	No-	14. Race - Amer Black, White Specify: Whi	, etc.
	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-	4or 5+)	life. I	dent's Usu kind of wo DO NOT u	ork done d ise retired	uring most of	working		Kind of Business/leducation	
	To Be C	17. Father's Name (First, Middle, Last) Lester Harmon	1					18. Mother's Clora l	Name (First, Mid Melton	dle, Maide	en Sumame)	
		19a. Informant's Name/Relationship (7 Twila Cavey (daugh									or Town, State, Z.	
		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Mother (Specific		tate	Place of Dispo	natory or o	other place		Date	Kee	Location - City or 1	
once.		4 □ Donation 5 ☒ Other (Specify 21. Signature of Funeral Service Licen → Guge Haught 3			22	. Name ar	nd Addres	s of FacilityH	18-06 aight Fu esville,	neral	esville. L Home & 21784	
an :al :er	edical Examiner	shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Equantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Slul Due to (c) Due to (c) C.	or as a consequence as	uence of): uence of):	nar	y h	yper	tensia	1		Interval Between Onset and Death MWWW.
	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Feta nt at time of d	ıl death 3 □	Ectopic p Other (sp				-	23d. Date of deliver Month	∕ery Day Year
	۵	Part II. Other significant conditions co	ntributing to dea	ath but not res	ulting in the u	ndertying o	cause give	n in Part I.				the cause of death?
	Completed								24a. W au pe 1 🗆 Ye	topsy erformed?	prior to o	opsy findings available ompletion of cause of 2 No
	o Be	25. Was case referred to medical examiner? 1 Tyes 2 No	Hospital: 1 Min	patient 2 🗆	ER/Outpatien	t 3 D0	Othe	-	Death (Check on		6 □Other (Spec	4.1
= 1	$\vdash \downarrow$	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of		28b. Time of Injury		28c. Injury Work				ury occurred	1197
en cy me	Certification:	3 Suicide 6 Could not be 4 Homicide determined		of Injury - At h g, etc. <i>(Specil</i>	ome, farm, str	eet, factor	y, office			n (Street a Town, Sta	and Number or Rui te)	ral Route Number,
compressity miled in by	ledical (29a. Certifying Ph (Check only one) 2 Medical Exam	iner: On the ba	sis of examina	owledge death ition and/or inv	estigation	at the tim	e, date and pl inion, death o	ace and due to t occurred at the tin	ha cawee(ne, date ar	e) and manner ac- nd place, and due	to the cause(s)
	Me	29b. Signature and title of certifier				290	c. License	number		l _	ate signed (Month)	, Day, Year)
		30. Name and address of person who o	C MI	of death (Item	n 220) (Tuno	1	2006	2975	Note the second	13/1	5/0%	
				Of Goddin (itto)	11 234) (1900.	Print)						

			- FOr		partment of He		P	2006 6	18313
			1 - State Registrar 1. Decedent's Name (First, Middle, Last)		Fillicale of D		Reg. No	0.000	3. Time of Death
	Physicia /Medic		SHIRLEY DU	DAB	RASKY		Month Da	4,2006	8:40PM
	Examin		4a. Facility Name (If not institution, give street and number)	SPITAL	4b. City, Town, or/Lo	ocation of Death	E	c. County of Death n/a	
_	Funeral			e (In yrs. last birthda		If Under 24 Hrs. 8.	Date of Birth (Month, Day, Year		ace (State or Foreign
	Director		214-32-1958 1□M 2¬₹F	70 Yrs.	Months Days			935 Mary	_
	pu ,		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Logation			10	d. Inside City Limits
	anyla shov	5							1X Yes 2 □ No
	Ne M	ecto	Maryland n/a 10e. Street and Number	Ba.	Ltimore		100.0	itizen of What Count	
	a or	Funeral Director	1817 Wilhelm Street		21223			nited Stat	
	leath	era	11 Marital Status 12. Was Decedent		3. Was Decedent of Hisp	panic Origin? (Specify	Yes or No-	14. Race - America	n Indian,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heelih and Mental Hygiene. It heelih and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic svent, its Medical Examinat must be notified at	by Fun	Armed Forces? 1 Never Married 2 Married 1 Yes 2 Married 3 Widowed 4 Divorced Year or Dates:		If Yes, specify Cuban, 1 ☐ Yes 2 ☑ No	Mexican, Puerto Rica Specify:	an, etc.)	Black, White, e	
9	2 hou	ted	15. Decedent's Education	16a. De	cedent's Usual Occupation	on	16b. I	Kind of Business/Indu	ustry
215	filed within 72 Hygiene. other than "nater, the Medic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or:	5+)	. DO NOT use retired)	ing most of working			
21	filed withi Hygiene. other ther ent, I've M	Son	11 0	ho	memaker		hon		
Maryland 21215-0036	ital Hid oth	Be	17. Father's Name (First, Middle, Last)		1	8. Mother's Name (Fi			
<u>Y</u>	should be and Mental s marked o umatic svs	၉	Charles Louis Pailer	105 14	illing Address (Street and	Phoebe El			Codel
Mai	12 sho h and 7 is my trauma		19a. Informant's Name/Relationship (Type, Print)						
	is 1 and 2 of Heelth itam 27 other tra	1 3	Cheryl Dabrasky / Daughter 20a. Method of Disposition	20b. Place of Dis	25 Wilhelm S	Date		Mary Land Location - City or Tow	
р	Pages nent of nnt: If its iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		rematory or other place)	3/20/0	Chan	. marri 11 -	Maraniana
Baltimore,		1	21. Signature of Funeral Service Licensee		d Vet. Cem. 22. Name and Address			wnsville,	
B	permit. Departr Imports sny inju		> Unn Rowe.	-	4107 Wilker				
			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li	d the death. Do not					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	11 ABST	DUCTIVE T-	ZILMON,	4RVD,	SEASE	Onset and Death
	/Medical		resulting in death)	a consequence of):			1		
	Examiner		Sequentially list conditions. b. Hyperia	LTENSI	VE CARL	DIOVASCI	ILAR !)ISEASE	
	be sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of):	& HEAD	ST FAI	11100		
	and and Il-tran	хап	that initiated events c.	a consequence of):		(/ ////	-414		
8760,	ate be executed thysicien and the burial-transit	dicai E							
687	the the	edic	U						
Box	death certifica attending ph d for use as th	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 morus? 23c. If yes, outcome	2 Fetal death	3 □Ectopic pregnancy			23d. Date of deliver	y Day Year
P.O. E	the the	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	t time of death	5 Other (specify)				
	es that thighed by	by Ph	Part II. Other significant conditions contributing to death b	out not resulting in the	underlying cause given	in Part I.	23e. Did tobacco	use contribute to the	e cause of death?
rds	w require been sig should b	ed b					1 🗆 Yes	2 □ No 3 □ Proba	ibly 4 Onknown
of Vital Records,	e law requ has been je 2 should	Completed					24a. Was an autopsy	24b. Were autop	sy findings available inpletion of cause of
R		Con					performed? 1 ☐ Yes 2 ☐ K	death?	
Vita	Physician: The rather contificate rather rate director, page	Be	25. Was case referred to medical examiner? Hospital:		Other	26. Place of Death (C			
of	Phys this rai dir	<u>1</u>	1 Tes 2 No 1 Inpati		IERI 3 DOA	4 Nuising Home	5 Residence I. Describe how inj	6 ☐ Other (Specify,)
	ding h. After fune	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	y Year) Injur	y Work?	es 2 No		,	
Division	or Attendiater death Director: A	fica	2 () () () () () () () () () (jury - At home, farm, tc. (Specify)	street, factory, office	28f.	Location (Street a	and Number or Rural	Route Number,
ā	s afte	Certification:	4 Homicide determined building, e	с. (эреспу)			City or Town, Sta	10)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (29a. Certifier 1 Certifying Physician: To the best (Check only one) 2 Medical Examiner: On the basis of and manner standard ma	of examination and/or	eath occurred at the time investigation, in my opin	e, date and place, and nion, death occurred	due to the cause(at the time, date a	s) and manner as stand place, and due to	ated. the cause(s)
	o the	Med	29b. Signature)and title of certifier		29c. License r		-	ate signed (Month, D	Day, Year)
	- >- 0		Kasita R. Cri	NE M	D Do	03035	55 M	arch.	14.2001.
	12		30. Name)and address of person who completed cause of	death (Item 23a) (Tyr	pe, Print) Bo	ON SE	COUR	S Hoca	o TAI
	Sta		Me -	rar's Signature				- 1,00	1 1 1 1 1
	Regist	rar	MAR 2 0 2006	1 No File					

Charles Davis 06-01854 NJM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,PII_27,pen/F_2855.5/5/06 TT.

			Unpend Item#23a,F 1- For State Registrar	State	of Maryla				ealth a Death	and M		giene Reg. No	000	08314	Î
		ī	1. Decedent's Name (First, Middle, Las	it)							2. Date of Dea		. V	3. Time of Deat	h
	Physici /Medi		Charles Bernard Davis							þ	March	15	200	6 1317	М
	Examir		4a. Facility Name (If not institution, give	street and no	ımber)		4b. City,	Town, or	Location o	f Death		4c.	County of Dea	ith	
			Southern Maryla	ınd Hos	pital		C1	into	n					George's	
	Funeral		5. Social Security Number 6. S	ex ŽM 2□F		. last birthday)	If Under Months	r 1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Day December	h y, Year)	9. Bir	rthplace (State or Fore	əign
	Director		220 10 4033		84	Yrs.					December	27,	1921 Was	hington, D.C	٠
3	and and		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City Lim	nits
6	de h	ö	Maryland Prince Geo	rae's	Upp	er Marlbo	oro							1 T Yes 2 □	No
4	288	Directo	10e. Street and Number	. 5	-11		10f. Zip	Code				10a. Citi	izen of What C	ountry?	
1	30 01		9221 Goldenrod Lane				207	72					S.A.	,	
200	ms 2	Funeral	11. Marital Status		edent Ever in	J.S. 13.			spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		14. Race - Am	erican Indian,	
٥	or its	Ţ	1 Never Married 2 Married		2 🗆 No					, Puerto I	Rican, etc.)		Black, Whi		
3	rat',	1 by	3 Widowed 4 Divorced	If Yes, G Year or I	ive Dates: 1945		1 LI Yes	261 No	Specify:				Specify: Wh	iite	
7275-0036	De lifed within 72 froms eller death with the Marylan half Hygiene. 10 other than "netural", or itsme 23a or 28e-1 show svent, its Modical Examinar must be notified at	Completed	15. Decedent's Ed (Specify only highest gra)	16a. Dece	dent's Usu kind of wo	al Occupa	ition luring most)	of worki	ng	16b. Ki	nd of Business	Vindustry	
Z :	9 9	Ig II	Elementary/Secondary (0-12)		(1-4or 5+)							F. 1-	1 . C		
V	hart hart nt, th		17. Father's Name (First, Middle, Last)			Mecha	nical	Engil		da Massa	(Pirst, Middle,		eral Gove	rnment	
מבי	d of s	Be	Charles Bernard Davis	S.n							Martin	maiden	Sumame)		
Maryland 21215-0036	d Me	은	19a. Informant's Name/Relationship (10b Mailie	a Addross	(Street			/ Route Numbe	City	s Town State	Zie Cedel	
ב ב	4 4 T W		Herbert Davis, Broth			1					eld, Vir			zip Code)	
e, 5	Hear tem other		20a. Method of Disposition		20b.	Place of Dispo	sition (Na	me of			ate VIII		cation - City or	Town, State	
OF S	y or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		State Ft	<i>cemetery, cier</i> Lincolr			1		h 2000		-		
daitimore,	Department of himportant: if ite any injury or ot once.		21. Signature of Funeral Service Licen			22	. Name ar	nd Addres			4, 2006	bren	itwood, M	aryland	_
ă			1 Ologanduas	ARat	21				s of Facility Home Iv Spri		l., Laure	1 MC	20707		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	lications that	caused the dea								20707	Approximate	
Р	hysician		Immediate Cause (Final		tensive a	thoroga1	orotio	oord.	iovoco	.1an a	lianaa			Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)		(or as a conse		eroric	. Caru	iovasci	Har (usease				
=	xaminer		Conventially list conditions	h											
T) =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conse	quence of):									
di ca	and	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c											
STOU,	physician and the burial-translt	Û	rosaning in dodairy East	Due to	(or as a conse	quence of):									
	physi the t	dicai		d										V	
.O. BOX of	attending p	Physician/Me	IF FEMALE:	23c If yes ou	itcome of pregr	ancy							14.65		
מסא	atten for u	clan	in the past 12 months?	1 🗆 Live	birth 2 ☐ Fet	aldeath 3□	Ectopic pi Other (sp					1	23d. Date of de Month	livery Day Year	
; §	y the	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkn		30201	1 Other (a)	ocity)							
) j	ned b	by Pt	Part II. Other significant conditions co	ontributing to d	leath but not re	sulting in the u	nderlying c	ause give	n in Part I.		23e. Did to	bacco u	se contribute to	the cause of death?	
Records,	s been signed t	d b	Inanition								1 🗆 Y	es 2[□No 3□Pi	robably 4 Unknow	wn
	. 0.76	lete									24a. Was a	an	24b. Were as	utonsy findings availab	hle
בי הער הער	و ع	Completed									autop:	med?	prior to death?	utopsy findings availat completion of cause o	of
	certificete rector, pag	0	25. Was case referred to medical						26 Place	of Death	1 Yes Check only or	2 □ No	1 200 2 05	2 LI No	
_ a	is certific director,	To B	examiner? 1√2Yes 2 □ No	Hospital: 1 🔲	Inpatient 2	X ER/Outpatien	t 3 🗆 DC	A Othe	c		ne 5 ☐ Resid	9100	Other (Spe	cifv)	
	ter th nerat		27. Manner of Death 1 △Natural 5 □ Pending	28a. Date	of Injury th, Day Year)	28b. Time of	2	8c. Injury Work			8d. Describe h				
DIVISION or Attending	death. ctor: Af y the fu	atlc	2 ☐ Accident investigation		an, bay roar,	,,	М		es 2□N	lo					
	irsct irsct irsct	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	256. Place	of Injury - At h	iome, farm, stre	eet, factory	, office		2	8f. Location (S City or Town	treet and	d Number or Ri	ural Route Number,	
ב ב	raid Iled ir														
UI the Hospitel or	within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical	29a. Certifier 1□ Certifying Ph	mer: On the t	easis of examin	cwladge, death ation and/or inv	estigation	at the tim , in my op	a date and inion, death	place, a h occurre	nd due to thaic d at the time, d	aus (s) late and	and manner as place, and due	stated. to the cause(s)	
the c	thin of the omple	Med	29b. Signature and Ittle of certifier	and man	iner stated.			. License							
<u> </u>	81≅				1/4		230						e signed <i>(Mont</i>		
an K	10	1	30 Name and address of	omal-uki	on of death #	m 02c\ 7	Delasti		CME			ria —	rch, 17	, 2000	
P			30. Name and address of person who o	AN	oe ur death (Ifé	m zoa) (Type,		1 Per	ın Str	reet	Baltin	nore	, Maryl	and 21201	
	Sta	te	31. Date filed (Month, Day, Year)	320	Registrar's Sign	ature /							,,-		
	Registr		MAR 2 0 20	DE MA	due 1	J	-								

			For State		State of	f Marylar			nt of H		Mental H	_	000	00015
	6 C		Registrar 1. Decedent's Nam	e (First, Middle, L	ast)			7111104	.0 0, 1	Joann	2. Date of D			3. Time of Death
	Physici		John	Alber		ho					Month March		ay Year 18, 2006	8:15A M
	/Medic Examir		4a. Facility Name (4b. City	, Town, or	Location of Dea			c. County of Dea	
	LXUIIII		Stella M	Maris Hos	nice				Tows	n n			Ra1	timore
20	Funeral		5. Social Security N		Sex	7. Age (In yrs.	last birthday)		r 1 Year	If Under 24 Hrs		Sirth Yea	9 Bir	tholace (State or Foreign
	Director		335-07-1	904	1 ∑ M 2□F	88	Yrs.	Months	Days	Hours Min	Sept.		1917	ilL
	pu »		Usual Residence o 10a, State	Decedent 10b. County		100 C	ity, Town or Lo	tio-			•			404 1-14 00 11 0
	anyla shov	<u>_</u>	Toa. State	,		100.01								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	death with the Maryland ms 23a or 28a-f show r must be notified at	Funeral Director	MD 10e. Street and Nu		imore		T	imoni				10- 0	Nai	
	with	ā						101. 2	p Code			10g. C	itizen of What Co	ountry ?
	ours after death with ai', or items 23a or Examinat must be	erai	2525 Po 11, Marital Status	t Spring		dent Ever in U	18 13	Was Dec		21093	Specific Vac or A	lo-	USA 14. Race - Ame	nican Indian
400		'n		ried 2 Married	Armed Fo	rces?	7.5.	If Yes, spe	ecify Cubai	n, Mexican, Puei	Specify Yes or Noto Rican, etc.)	40	Black, Whit	
336	urs af	by [3 Widowed		1 □ Yes If Yes, Giv Year or Da	ates:		1 🗆 Yes	2X No	Specify:			Specify: W	hite
9	within 72 hours after ene. than "natural", or ite ne Medical Evantion	ted	/6	15. Decedent's E			16a. Dece	dent's Usi	ual Occupa	tion		16b.	Kind of Business	
215	hin 7 an "r Med	Completed	Efementary/Seco	ondary (0-12)	College (1	-4or 5+)	life.	DO NOT	use retired;	uring most of wo	orking			
21	filed with Hygiene other that	Con			5+]	Manag	ement				Consulta	int
5	be filed withintal Hygiene. Id other than	Be	17. Father's Name	(First, Middle, Las	t)					18. Mother's Na	me (First, Middi	le, Maide	en Sumame)	
yla	Men Marke Marke	P	John D								line La			
Maryland 21215-0036	and and	1 3	19a. Informant's N	ame/Relationship	(Type, Print)		19b. Maili	ng Addres	s (Street a	nd Number or R	ural Route Num	ber, City	or Town, State, 2	Zip Code)
	and lealth m 27 har t		Patric 20a. Method of Dis	ia M. Do	naho W	life	2525 Place of Dispo			ng Road,	Timoni Date	_		
5	Pages hent of Hunt: If ite		1 🗆 Burial 2	XCremation 3			cemetery, cre	matory or	other place	1		20¢. I	Location - City or	rown, State
Baltimore,	t. Pa			5 ☐ Other (Spec		Ca	rroll (0/06	Н	lampstead	d, MD
Bal	permit. Pages 1 Department of H Important: If ite any injury or oth		21. Signature of Fu	Ineral Service Lice	insee ,					s of Facility				stown Road
			23 . Part1. Enter t	the disease or cor	nolications that co	aused the dea				eral Hom			rstown,	MD 21136 Approximate
			shock, or hea	art failure. List only	one cause on e	ach line.	un. Do not din	ter the mo	de or dying	, such as cardia		arrest,	10	Interval Between Onset and Death
	Physician /Medical		resulting in death)	on	a	hron	100	en	a	fal	ne			yeurs
	Examiner				L	or as a cons	A) Strammen nako			1				Ja
		ē	if any, leading to in cause. Enter Under Cause (Disease or	inditions, inmediate	Due to (or as a consec	quence of):	(000						Jears .
M	s be executed sician and burial-transit	Examin	Cause (Disease or that initiated events	r injury		'								~
•	en ar rial-ti	Ě	resulting in death)	Last	Due to (or as a consec	quence of):							
15 A 8760	cate be execul physician and the burial-trar	dicai		•	d									
.: 9	certifica nding ph use as t	Med	IF FEMALE:											
ô	leath certific attending p	an/l	23b. Was deceden			irth 2 Feta	al death 3]Ectopic p	oregnancy			1	23d. Date of del	ivery Day Year
2006	0 0 0	Physician/Me	1 ☐ Yes 21 9 ☐ Unknown	De No	4☐ Pregna 9☐ Unkno	ant at time of one	death 5	Other (s	pecify)				WORTH	Day 16a1
	± 5° Se	Ph)	Part II. Other signif		contributing to de	eath but not res	sulting in the u	ndarhina	cause owe	n in Part I	23a Did	tobacco	use contribute to	the cause of death?
18, rds,	S 15 0	d by	, at the same significant		ooming to do	an barnor roc	satting in the a	in conjung	oause give	ir iir i care i.				obably 4 Unknown
I I		etec												
MARCH al Rec	e la has je 2	Completed									24a. Wa auto	s an opsy formed?	prior to death?	topsy findings available completion of cause of
MA	T ale		05.141								1 ☐ Yes	212(N		2 × No
੍ਰ ਝ) Be	25. Was case referexaminer?		Hospitaf:		7500		OA Othe	-	ath Check only		. 70	
AHC of		: To	27. Manner of Deat			npatient 2 of Injury h, Day Year)	ER/Outpatier 28b. Time o		28c. Injury Work	4 EX INUISING	28d. Describe		6 □Other (Spe ury occurred	cify)
DONAHO sion of	Attending F r death. sctor: After by the funer	tio	1 X Natural 2 ☐ Accident	5 Pending investigate		h, Day Year)	Injury	М		? 'es 2 □ No			•	
	Attendi or death. ector: A by the fu	ifice	3 ☐ Suicide 4 ☐ Homicide	6 Could not determined	286. Place	of Injury - At h	iome, farm, sti	reet, facto	ry, office					ıral Route Number,
JOHN	epitai or Attend nours after death naral Director: /	Certification:	4 [Homeda		Duligir	ng, etc. <i>(Speci</i>	19)				City or To	own, Sta	(0)	
7	To the Hospital of within 24 hours at To the Funaral D completely filled in		29a. Certifier (Check only	1 ☐ Certifying P 2 ☐ Medical Exa	hysician: To the	best of my kno	owledge, deat	h occurred	at the tim	e, date and place	e, and due to the	e cause(s) and manner as	stated.
	To the Hos within 24 h To the Fur completely	Medical	one)		and mano	per stated.								
	Vit.		29b. Signature and	Title of Certifier	11	Jac la	1 111		c. License	7 7 (1		W .	ate signed (Mont	M 202
	1		TO N	nestin	e V	Juda	II VV			- / +		11/0	AND C	2000
	10		_	ress of person who		1	m 23a) (Туре, <i>тит жие</i> г		TEN	DO N D 77.	TMONTTINE	247	23000	
	Sta	te	31. Date filed Mag	TNE WRIGH	1/07	2300 egistrar's Sign	DULANE ature	I VAI	LLEY .	RUAD TI	MONIUM,	MD	21093	
	Registr	- 5	MA	KZ U ZU	10 Ales	15°	State of the state							

			1 - For State Registrar	State of Ma	arylan		artmen rtificat			and Me	ental Hy	/gien	nn	6 (1881	6
	Physici /Medi		1. Decedent's Name (First, Middle, La Charles Howard	st) Daugher	ty, Ji	r.					2. Date of D Month March	16, D	2006	Yeer	3. Time of E 2:10 A	
	Examir		4a. Facility Name (If not institution, giv Summit Park Mariner	e street and number)				Town, or ISVIll	Location o	of Death		Bâ	c County of	of Death C	1	
	Funeral Director		217-10-0479	ex Дм 2□ F 82	e (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. 8 Min.	B. Date of B. Month, D eDruar	y 21°	1924	9. Birthpl	lace (State or Tand	Foreign
	ryland thow		Usual Residence of Decedent 10a. State 10b. County			y, Town or Lo	cation							10	0d. Inside City	
	the Ma 28a-f s	recto	Maryland N/A 10e, Street and Number		Ва	ltimore	10f. Zip	Code				100.0	itizen of W	That Court	1 💢 Yes 2	2 □ No
	23s or	rai Di	825 Freeman Street				212					109. [itizen of W	mat Coun	uy:	
9036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 ie marked other then "natural", or items 23s or 28s-1 show any injury or other treumatic event, the Madicial Examinar must be notified at ance.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 🂢 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates:		τ '	Was Deced f Yes, spec 1 ☐ Yes	offy Cubar	spanic Origin, Mexican Specify:	gin? (Spec , Puerto R	rfy Yes or N ican, etc.)	0-	Black	· America K, White, & White	etc.	-
21215-0036	in 72 ho a "natu ladical	ojetec	15. Decedent's Ed (Specify only highest gra	de completed)		16a. Deced (Give	dent's Usua kind of wo DO NOT us	rk done d	urina most	of working	9	16b.	Kind of Bu	siness/Ind	lustry	-
212	ygiene. ygiene. her ther	Com	Elementary/Secondary (0-12)	College (1-4or 5	+)	Mainter			n			1	ırch			
Maryland	nould be fil i Mental H harked ott hatic even	To Be		rty, Sr.					Mary	Etta	(First, Middle Tolson					
Mai	ss 1 and 2 sh of Health and Item 27 le n other treun		19a. Informant's Name/Relationship (Palma Conrad/Daughter	Type, Print) –		196. Mailin	ng Address G EWOO C	Avenu	nd Numbe Je Bal	r or Rural ltimore	Route Numb e Maryl	and	21228	State, Zip	Code)	
Baltimore,	Pages 1 and the ment of He mant: If Item ury or other		20a. Method of Disposition 1 Burial 2 Coremation 3 4 Donation 5 Other (Specific		c	lace of Dispo emetery, cren .1top Set	natory or o	ther place	" 3	B/17/06			ocation - 0			
- Balt	permit. Departi Import any inj		21. Signature of Funeral Service Licer Mustura A.	see Christina Alton	L. Hi	lton 22 5	Name an eopard 305 Ha	d Addres J. Ri r tor d	s of Facility ICK III Road	hc Bålti	more Ma	rylar	nd 212	214		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused one cause on each lin	e.	R	er the mod		tail	cardiac or	respiratory a	arrest,			Approximate Interval Betwee Onset and De	
8760,	ate be executed thysicien and the burial-transit	licai Examiner	Sequentially list conditions, it any, seating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c Due to (or as a d.												
.O. Box 6	Attending Physician: The law requires that the death certificate be executed robating and are dath. To death actors against a page 2 should be detached for use as the burial-transit by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of the control	2 Fetal	Idéath 3□	Ectopic pr						23d. Date Mon		ry Day Ye	ar
О.	uires thet signed b Id be deta	δ	Part II. Other significant conditions of	ontributing to death bu	it not resu	ulting in the ur	nderlying ca	ause give	n in Part I.			tobacco Yes 2			e cause of dea	
Records,	e law requir has been si je 2 should i	Completed		Premo	nio	L					24a. Was		24b. W	ere autop	sy findings av	ailable
	ysiclan: The is certificete hadirector, page			Dystlag	i							ormed?_	de	eath?		158 OI
=	ysiclar is certii directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	nt 2 🗆	ER/Outpatien	t 3□ DO	Othe	/	,	Check only 5 ☐ Res		€ □Otho	r (Specific	1	
_ _	ng Phy Iter thi Ineral (27. Manuar of Death 1 V Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	v	28b. Time of Injury		Bc. Injury Work			d. Describe				/	
Division of Vital		Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ry - At ho . <i>(Specif</i> y	ome, farm, stre	М	1 🗆 Y	es 2□N	-	f. Location (City or To	(Street a	nd Numbe	r or Rural	Route Numbe	9 <i>r</i> ,
_	Hospite 4 hours Funeral ely fillec	edical Ce	29a. Certifier 1 Certifying Ph	ysician: To the best of niner. On the basis of and manner stat	examinai	wledge, death	occurred a	at the time in my ope	e, date and Inion, deat	d place, an	d due to the at the time,	cause(s	s) and man	ner as sta nd due to	ated. the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	^	-			License		, 0			ate signed			,
)	7		Bull	Luo.				D3	69	42	-	Mo	wih	17,	2006	
9	1		30. Name and address of person who o	completed cause of de	ath (Item	23a) (Type, I	Print)	R	a. C	9 tor	yn'll	c,	M	2/	228	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signat	ture		,								

	W-24		1 - For State Registrar	State of	Marylar				ealth a	and M	ental Hy	giene Rag. No.		08317
	Physic	8	1. Decedent's Name (First, Middle, Las	st)	-						2. Date of De. Month	ath Day	Year	3. Time of Death
	Physici /Medi		Mildred	Dorsey							03	10	06	8:20P M
	Examir	ner	4a. Facility Name (If not institution, give	street and num	ber)				Location of	of Death			County of Death	
200	4 4		Casey House 5. Social Security Number 6. Security	27 7	Ago (In use	last birthday)		kvil.	Le If Under:	24 Hrs	8. Date of Birt	_	ontgome	
	Funeral Director			M 2 🔀 F /	62	Yrs.	Months		Hours	Min.	(Month, Da	y, Year)	Cou	oplace (State or Foreign untry) Virginia
			Usual Residence of Decedent		02						05 05	7.5	West	VIIGINIA
	how		10a. State 10b. County			ty, Town or Lo								10d. Inside City Limits
	Ba-f-	cto	MD Montgome	ry	h	Theaton								M∏Yes 2 □ No
	章 or 28	Director	10e. Street and Number					p Code				10g. Citiz	en of What Co	untry?
	ath w	ra	2805 Kingswell					0902				USA		
	item item	Funeral	11. Marital Status	12. Was Deced	es?	J.S. 13.	Was Dece If Yes, spi	edent of Hi ecify Cuba	spanic Ori n, Mexican	gin? (Spe i, Puerto l	cify Yes or No Rican, etc.)	- 1	 Race - Amer Black, White 	
36	I'. or	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Dat			1 🗆 Yes	2 X No	Specify:				Specify: B1	ack
ò	72 hours after death with the Maryland 'naturel', or Items 23a or 28a-1 ehow disal Examinat must be notified at		15. Decedent's Ed	ucation		16a. Dece	dent's Usi	ual Occupa	ation				d of Business/I	
215	within 7; ene. then "n	Completed	(Specify only highest gra	de completed) College (1-4	4or 5+)	(Give	kind of w DO NOT i	ork done d use retired	fu <i>ring</i> mosi)	t of workii	ng			
Baltimore, Maryland 21215-0036	giene.	Con	12th.	`		Contr	act	Speci	alis	t		II	BM	
p	be filed tal Hygid d other event.	Be (17. Father's Name (First, Middle, Last)					-	18. Mothe	r's Name	(First, Middle,	Maiden S	Su <i>mame)</i>	
<u>ya</u>	2 should be and Mental is marked or raumatic ever	P	Roscoe Tarver								e Thoma			
Jar	2 sh and is m	1	19a. Informant's Name/Relationship (7				-						Town, State, Z	ip Code)
e)	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 is marked other then "naturel; or items 23e or 28e-1 ehow other traumatic event. I'm Medical Exemples must be notified at	18	Kelli Dorsey/Da 20a. Method of Disposition	ughter	20b I	10 Wi Place of Dispo			2 Jama		Plain,		02130 ation - City or 1	Four State
و			1 🗗 Surial 2 ☐ Cremation 3 ☐			cemetery, crei	natory or	other place	9)			200. 200	ation - City or	own, State
Ë	그 문문을 .		4 □Donation 5 □Other (Specify 21. Signature of Funeral Service Licen		Qua	antico	Nati	onal	o of English	03-15	5-06	Triar	igle, V	A
Ba	Depa impo eny ic		21. Signature of 1 uneral service Ercen	R 00									eral Ho	
			23a. Parti. Enter the disease, or comp	olications that car	used the dear								D.C.	20011 Approximate
8760,	Physician /Medical sicien and physician and	ai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undeathying Cause (Disease or injury that initiated events resulting in death) Last	Due to (o	ras a consec ras a consec ras a consec	quence of):								
P.O. Box 687	death certificate e attending phy: id for use as the	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregna 9□Unknov	th 2 Feta nt at time of c vn	al death 3 death 5 death	Other (s						3d. Date of deliment	Day Year
	w requires that been signed should be del	þ	Part If. Other significant conditions of	ontributing to dea	ith but not res	sulting in the u	nderlying	cause give	en in Part I.			obacco us ∕es 2 🔀		the cause of death? bbably 4 Unknown
al Records,	The la ete has page 2	Completed											prior to c death?	topsy findings available ompletion of cause of 2 No
of Vital	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only o			
ō		2	1 Yes 2 No	1 □ In		ER/Outpatier 28b. Time of		UA	4 🗆 14u		ne 5 ☐ Resid 28d. Describe h			(fy) HOspice
o	ding h. After funer	tion	1 ☑Natural 5 ☐ Pending	(Month	Day Year)	Injury	м	28c. Injury Work	:? ∕es 2 🗀 I			ion injury	00041104	
Division	al or Attending s efter death. Il Director: After od in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place o	f Injury - At h g, etc. (Speci	ome, farm, str fy)					28f. Location (5 City or Tox		Number or Ru	ral Route Number,
	To the Hospital or within 24 hours efter To the Funeral Dir completely filled in	edical (29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the bas and manne	is of examina	owledge, death ation and/or in	h occurred vestigation	d at the tim	e, date an	d place, a	and due to the	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
	To the Within 2 To the complet	Me	29b. Signature and Me of certifier		. ^	١٠ ١١	29	c. License	number			29d. Date	signed (Month	, Day, Year)
	0) N/V		×	207	Г	3563	5			Marcl	h 13, 2	006
h	\		30. Name and address of person who	completed cause	of death (Iter	m 23a) (Type,								
2			Joseph Kaplan 60					Rocl	kvill	e, M	D.			
T.	Sta Registi		31. Date filed (Month, Day, Year) MAR 2 0 200	6 See	gistrar's Sign	ature	The same							

		1 - For Stata Registrar	State of N	Marylaı		artmen <i>rtificat</i>			nd M		iene eg. No.	96	08318
Physicia /Medica	75.	Decedent's Name (First, Middle, Last	Clar	a D.	Edw	ards				2. Date of Dea Month	Day	Year 2006	3. Time of Death
Examine		4a. Facility Name (If not institution, give 3205 St Ambrose 5. Social Security Number 6. Se	Avenue		last birthday)		1to	Location of			N/A	nty of Death	
Funeral Director			M 2X)F	77	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day 4-15-	, Year)	9. Birth Cou	place (State or Foreig intry) N.C.
e Maryland Ba-f show	ctor	10a. State 10b. County Md	N/A	10c. Ci	ity, Town or Lo Balt								10d. Inside City Limits 1X Yes 2 □ No
with the a or 2	2	10e. Street and Number 3205 St Ambrose A	***			10f. Zip		-		1	0g. Citizen o		ntry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, ira Medical Examinat Institute and once.	Completed by Funeral Director	11. Marital Status 1 Never Married XXMarried 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Yes 2 X If Yes, Give Year or Dates	?] No		Was Deced ff Yes, spec			in? (Spec Puerto P	cify Yes or No- Rican, etc.)	14. A	S A lace - Ameri lack, White, cify: B	
d within 72 hours atl glene. or than "natural", or ine Medical Exami	ompleted	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 8th grade		r 5+) N/A	(Give	dent's Usua kind of woi DO NOT us usewi	rk done d se retired)	ition uring most o	of workin	g	16b. Kind of		ndustry
i Hygi other	Be	17. Father's Name (First, Middle, Last)		N/A	по	usewi		18. Mother	s Name	(First, Middle, I	Home		
Menfa Menfa Brrked atic ev	2 B	Joseph Griffin						Hat	tie	Smallwo	od		
and 2 should be fill asalth and Menfal Hy n 27 is marked oth er traumatic event		19a. Informant's Name/Relationship (Ty George Edwards –								Route Number Balto,			o Code)
oermit. Pages 1 a Department of Hea mportant: If Item Iny injury or othe		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	9	Place of Dispondence	natory or or	ther place				20c. Location Randa		
permit. Departr imports any inj		21. gnature of Funeral Service Licens	CON	un	It 4:	300 1	Vabas		enue	arch F/I Baltimo	H We ore, M	st	1215
Pnysician /Medical		23a. P. rt1. Enter the disease, or compl nock, or heart faifure. List only or timm diate Cause (Finaf disease or condition re/ulting in death)	le cause con	usk	tic L	*		, such as ca			Sati	elle	Approximate Interval Between Onset and Death
Examine be executed physicien and the buriat-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Liseane or injury that initiated events resulting in death) Last	Due to (or a	s a consec	vec	ire	tot C		VV	ort.0	/		
If the death certificate be executed by the attending physicien and tached for use as the burial-transit	Physician/Medi	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	ıl death 3□	Ectopic pre						Date of delive	ery Day Year
igne bed	2	Part II. Other significant conditions cor	tributing to death	but not res	ulting in the ur	nderlying ca	iuse give	n in Part I.		23e. Did tob	_r	ntribute to the	he cause of death?
The ate h		25. Was case referred to medical									ned? VINo	prior to co death?	ppsy findings available mptetion of cause of 2 No
this at dia	0	examiner?	ospital: 1 lnpati 28a. Date of Inj (Month, Da	ury	ER/Outpatien 28b. Time of Injury		A Other	4 🗆 Nursi	ing Home	e 5 Reside	nce 6 🗆 O		(y)
	Serring	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of fr building, e	ifury - At ho	ome, farm, stre	eet, factory,	office		28	8f. Location (Str City or Town	eet and Nun , State)	nb er or Rura	al Route Number,
Hospi 4 hou Funer ely fill		29a. Certifier 1 Certifying Phys (Check only one) 1 Medical Examin	icien: To the best er: On the basis of and manner s	ot examina	wied e, death ition and/or inv	estigation,	in my opi	date and nion, death	tane an	id due to the ea d at the time, da	ues(e) and integrated and place	a and due to	taled. o the cause(s)
To the To the complet	2	29b. Signature and title of certifier	ablein	ñ	7)		License) - Z	06-3	7		3-13		Day, Year) 7 ZIZOY
State	0].	30. Name and address of person who co	mplet use of	death (Item nar's Signa	65	69	N.	Ga	19	St. 7	Out	m//	1)21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 6:00 p Dorothy May Fedikovich March 13 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Brooklyn Park Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 ☐ M 2√2 F Director 233-46-9642 1932 West Virginia 73 March 25, Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2406 or Items 23a Harriet Avenue 21230 U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status hours after 1 ☐ Yes 2 2 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify: Specify: <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced "naturel" White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry within 72 (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Cashier Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elizabeth Marie Robert Henry Jones Fluhardy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Delores Fedikovich- daughter 2404 Harriet Avenue, Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park 3/18/2006 Elkridge, MD 21. Signature of Furnal Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, INC. 7250 Washington Blvd., Elkridge, MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Examiner Due to or as a consequence of and I-transit that the death certificate be executed Due to (or as a consequence of): physician as the burial-1 Completed by Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown ģ Day Year 4☐Pregnant at time of death signed by the a d be detached for 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? sement, b 24a. Was an as autopsy performed? Yes 22 No page 2. No 1 Yes 1 Yes funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 1 ☐ Yes 2 No 4 wursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Hospitel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only To the 29b. Signatur and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53462

State Registrar

Maryland 21215-0036

Baltimore,

o يَ

of Vital Records,

Opkwood Road Glen Burnie, mp 21061

WD

32 Alegistrar's Signature

7845

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Muneus

31. Date filed (Month, Day, Year) MAR 2 0 2006

State Registrar

Box 68760

P.O. I

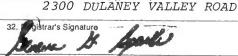
Division of Vital

FIORITO,

31. Date filed (Month, Day, Year)

EDDIE NAKHUDA, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



TIMONIUM

MD

21093

FRONA

Division of Vital Records, P.O. Box 68760.

		Please T 1 - For State Registrer	ype or Print in Bla State of Maryland	/ Depa		lealth and l	Mental Hy	•	6 08321
Physicia /Medic		Decedent's Name (First, Middle, Last) Frong	Fred	wo n			2. Date of De Month	aath Day Y	3. Time of Death
Examin Funeral Director		5. Social Security Number 6. Sex	tel of Baltmon	t <i>birthday)</i> Yrs.	Belt.	r Location of Death	8. Date of Bir (Month, Da 11/28/		Peath / A . Birthplace (State or Foreign MD
ith the Maryland or 28a-f show	Director	10a. State 10b. County MD BALTIMOR 10e. Street and Number	E B	Own or Lo	10f. Zip Code			10g. Citizen of Wh	
permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Maryland Depertment of Health and Mental Hygiene. Important: if flem 27 te marked other then "natural", or flems 23s or 28s-f show eny Injury or other treumatic event, the Medical Examiner must be notified at once.	by Funeral	8416 DORIAN ROAD 11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give X Year or Dates:		21208 Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (S	pecify Yes or No o Rican, etc.)	14. Race -	S.A. American Indian, White, etc. WHITE
ed within 72 ho ygiene. herthen "natur nt, the Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation 1 completed) College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most of wor		-	ness/Industry
nould be fill I Mental H narked ott natic ever	To Be	17. Father's Name (First, Middle, Last) HARRY		CORI		LILLIA	V		HIFFER
1 and 2 should Health and Men em 27 te marke other treumatic		19a. Informant's Name/Relationship (Type DIANE COHEN / DAU 20a. Method of Disposition	GHTER 20b. Place	105 (LD CROSS	ING DRIV		FIMORE, MI 20c. Location - Ci	21208
nit. Pages entment of I ortant: If its injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	BNAI	ISRA	NEL CONG. Name and Addre	03/17		BALTIMORE	E, MD
Deperturber	_	23a. Part1. Enter the disease, or complic	7			S		ISON & BRO	
Physician /Medical Examiner		shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	Cardici C	crhy	Thmis				Interval Between Onset and Death
buildie	dical Examiner	of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen	ice of):	c sis	enore.			I week
To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours effer death. To the Funsrel Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠No 9 □ Unknown	ic. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	•
quires thet n signed by uld be deta	۾	Part II. Other significant conditions cont	· diffule durch.	4		en in Part I.			ite to the cause of death? Probably 4 Unknown
: The law rec cete hes bee , page 2 shor	Completed	Chronic	obstructure pulm	ronary	disease			psy prio priod? dea	re autopsy findings available of to completion of cause of th? Yes 2 \sum No
ysicientis certification	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No	ospital: 1 ☑ Inpatient 2 ☐ ER	/Outpatier	t 3 DOA Oth	26. Place of Dea er: 4 ☐ Nursing H	- 7	one) dence 6 □Other	(Specify)
Attending Pt or death. ector: After th by the funeral	Certification;	27. Manner of Death 1 SNatural 5 Pending investigation 3 Suicide 6 Could not be determined	(Month, Day Year) 28e. Place of Injury - At home	b. Time of Injury	M 1	yat k? Yes 2 ☐ No	28f. Location (Street and Number	or Rural Route Number,
Hospitel or 24 hours eftu Funsrel Dir stely filled in	edical Cert	29a. Certifier 1⊠. Certifying Physi	building, etc. (Specify) cien: To the best of my knowle er: On the basis of examination and manner stated.	dge, deatl	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	city or Too	cause(s) and mann	er as stated. I due to the cause(s)
To the within To the	Me	29b. Signature and title of certifier	J. 40		29c. Licens	e number		29d. Date signed (#	Month, Day, Year)
24		30. Name and address of person who con Richer	npleted cause of death (Item 23	3a) (Туре, 450) (Print) 0755 Fells Red	Lutherville	,4421053		
Sta Registri	ar	31. Date filed (Month, Day, Year) MAR 2 0 2006	32. Registrar's Signature	Son	A.				

		C	ose 0. Ga 6-01851			e or Pr									_	ole.		
		C	T State Registrar		St	ate of N	Marylan	-			lealth a Death		lental H	ygien Reg. N	000	6	0.832	2
			Decedent's Nam	ne (First, Midd	le, Last)								2. Date of	-	0.()	<u> </u>	3. Time of D	eath
1	Physic		Jose Ma	nuel	Orteo	a Gai	rcia						Month March		ay .3 2	Year 2006	1:55	
	/Medi Examir		4a. Fecility Name (4b. City,	Town, or	Location of	ol Death	rarci		c. County		1: 55	<u> P</u>
1		iei	Universi	ty Hos	pital			land blinds do 1	Ba	alti r1 Year					N/A			
	Funeral Director		un	vumber	6. Sex		36 (in yrs. i	last birthday) Yrs.	Months		Hours	Min.	8. Date of the (Month), 11 - 1	Day, Yea	3)	9. Birtho Cour Mex	lace (State or I	=oreign
			Usual Residence of	f Decedent			30						11-1	2-05		Mex	100	
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "neturel", or items 23s or 28s-f show other treumatic event, its Medical Examinar must be notitied at	tor	10a. State Mass	10b. Count	′			r, Town or Lo								1	0d. Inside City 1 ☐ Yes 2	
	h the	Funeral Director	10e. Street and Nu	mber					10f. Zip	p Code		-		10g. C	itizen of W	/hal Cour	itry?	
	th with	a D	44 Alve	e St.					01	420				Mex	ico			
	dea	ner	11. Marital Status		12. V	Vas Deceder	t Ever in U.	S. 13.	Was Dece	dent of H	ispanic Ori	gin? (Sp	ecify Yes or I Rican, etc.)		14. Race		an Indian,	
98	or it	F	1 Never Man		ried 1	Yes 2 Yes, Give	No				Specify:					k, White, Wh		
8	ure!	d by	3 Widowed			ear or Dates	:											
21215-0036	n 72	Completed		cify only highe		npleted)		16a. Dece (Give	deni's Usu kind of wa DO NOT u	al Occupi ork done d	ation <i>during</i> mosi ()	t of work	ing	16b.	Kind of Bu	siness/Ind	dustry	
12	withi 1906 than	E	Elementary/Second 9th			College (1-4o	r 5+)		chan		,			Та	ndaa			
p	Hygi other	BeC	17. Father's Name		Last)			Me	Chai	110	18. Mothe	r's Name	First, Mida		ndsc			
a	Aenta Aenta Treed	To B	Porfiri	o Ort	ega						Cata	alir	na Ga	rcia				
Maryland	12 should be filled within in and Mental Hygiene. 7 is marked other than "r		19a. Informant's N	ame/Relation	ship <i>(Type, F</i>	Print)		19b. Mailin	ng Address	s (Street a	and Numbe	or Rura	Al Route Nun	ber, City	or Town,	State, Zip	Code)	
	and 2 patth n 27 i		Manuel	Contr	eras			2 Ni	chol	as	St.	Fito	chbur	g,MA	SS 0	142	0	
Baltimore,	permit. Pages 1 and 2 Depertment of Health a Important: If Item 27 is eny injury or other tre		1 🗆 Burial 2	Cemetery, crematory or other place)											localion -			
Ħ	nit. Figure ortan					/	/	22	. Name ar	nd Addres	s of Facilit	y Wes	lev (Chav	is.J	r.	FH	
ä	Depermine Depermine on the property is any in property		1///	s ar	MA	A	2										21231	
	Physician		Immediate Cause	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fature. List only one cause on each line. mmediate Cause (Final sissesse or condition esulting in death) a. Complications of combines drug(co cause and benevolustepine esulting in death) Due to (or as a consequence of):											Approximate Injerval Betwe Onset and De	en ath		
	/Medical		disease or condition resulting in death)	ori	a	Due to (or a	is a consequ	uence ol):	woln	ed di	resico	laine	chol u	police	tor re	.)		
	Examiner		Sequentially list co	nditions	b													
	uted J ansit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated event	nmediate erlying injury	₹	Due to (or a	s a consequ	ience of):										
60,	be executed icien and burial-transit	_	resulting in death)		c	Due to (or a	s a consequ	uence of):										
6876	rtificate being physicie	dic			d													
Box (leath certifii ettending p	/Me	IF FEMALE: 23b. Was deceder	u prognant	23c. If	yes, oulcom	e of pregnar	ncy							23d. Date	of delive	D/	
.O. Bo	0 0	Physician/Medical	in the past 12 1 Yes 2 I	months?	4	□Live birth □Pregnant: □Unknown			Ectopic pi Other (sp					.	Mon		Day Yea	ar
4	The law requires that the site has been signed by the bage 2 should be detache	F	Part II. Other signi	ficant conditi	ons contribu	ting to death	bul nol resu	ılling in the u	nderlying o	cause give	en in Part I.		23e. Did	tobacco	use contri	bute to th	e cause ol dea	ath?
ds,	uires Isign Id be	d by								_			10	Yes 2	2 ⋈ No	3 🗀 Prob	ably 4 ∐Uni	known
S	w requir been si should	lete											24a. Wt	ıs an	24b. W	ere autor	osy lindings av	ailable
of Vital Record	The lay te has age 2	Completed			,								aut	opsy formed?	d	ior to cor eath?	npletion of cau	se of
ta	ician: Th certificate rector, pag	0	25. Was case refer	rred to medica	ı						26 Place	of Death	1/2 Yes		0 1	₽4/es	2 No	
<u>></u>	Physician: this certific ral director,	ToB	examiner? 1x⊟xYes 2□	No	Hospi	tal: XX tnpal	ien∣ 2□E	ER/Outpatien	t 3 🗆 DC	Othe			ne 5 ☐ Re		6 ∏Othe	r (Specifi	•)	
	ding Phys n. After this funeral di	딭	27. Manner of Deat	th	28	a. Date of In	jury	28b Time of		28c. Injury Work			28d. Describ				/	
Ö	ath. or: Af	atio	2 Accident investigation March 4, 2006 7:43 PM 1 Yes 2 2 No Who															
Division	r Atte	Certification:	3 Suicide 4 Homicide	6 X Could deter		Be. Place of In	njury - Al hor	me, larm, str	eet, factor	y, office			28l. Location City or T	(Street a	nd Numbe	r or Rura	Route Numbe	r. 0
	urs of rel DI	S			N.	- 6	no on	hogh	van								ond, Sea	Dre)
	To the Hospital or Attending Physician: The la within 24 hours efter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier (Check only one)	1☐ Certifyi ŽXMedica	Examiner:	n: To the bes On the basis and manner s	of examinati	wledge, death ion and/or inv	occurred restigation	at the tim	ie, date and pinion, deat	d place, a th occurr	and due to the	e cause(: e, date ar	s) and mar nd place, a	ner as st nd due to	ated. the cause(s)	
	Withi To the	ž	29b. Signature and	title of certifie	or				290	c. License	number			29d. D	ate signed	(Month, I	Day, Year)	
•	. 0		Ja	sholy	De	of?	mo			OC.	ME			Mar	ch 17	, 2C	06	
	31		30. Name and add	ress of person	who comple	ted cause of	death (ftem	23а) (Туре,	-	Pen	n Str	eet	Baltin				21201	
	Sta Registr	-	31. Date filed (Mor	ith, Day-Year		32. Reci	rar's Signat	ure	p									
				MAR 2	U 2008	Ma	Page .	B-A										

DHMH 17 Rev 1/2001

ORIGINAL

			Tor State Registrar		Maryland /		rtment <i>ificate</i>			and M	,	giene Reg. No	nna	08323
変	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, L. Edward Will 4a. Facility Name (If not institution, gi	Viam (Brubb		4b. City, T	own, or	Location o	of Death	2. Date of De Month Mavcl	1 Pay	QUOK County of Dea	3. Time of Death P, 30 PM
er i	Funeral Director				tended (Age (In yrs. last t	birthday)	Balt If Under 1 Months		ore If Under a	24 Hrs. Min.	8. Date of Bin (Month, Da	th	9. Bir	thplace (State or Foreign ountry)
(lide)	D		Usual Residence of Decedent 10a. State 10b. County		10c. City, To		ation				1-13-	-49		D 10d. Inside City Limits
	a-f sho	ctor	MD			timo								MYes 2 □ No
	with the	Director	10e. Street and Number 404 S. Castle	St			10f. Zip (231				zen of What C	ountry?
21215-0036	be filed within 72 hours after death with the Maryland nat Hygiene. d other than "natural", or Items 23e or 28e-1 show event, the Mudical Exart and must be rediffed at	d by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1XX es 2[If Yes, Give Year or Date	s? □No s:	1[Yes 2	ent of His by Cuban	spanic Origin, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	-	S.A. 14. Race - Am. Black, Whi Specify: W	te, etc.
215-	ihin 72 l e. en "net Medice	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	ducation ade completed) College (1-4d		ia. Decede (Give ki life. Do	int's Usual ind of work O NOT use	done di	tion uring most	of worki	ing	16b. Ki	nd of Business	/Industry
	filed within Hygiene. Ither than "		GED 17. Father's Name (First, Middle, Las				Lab			r's Name	(First, Middle,		tracti	.ng
Maryland	2 should be filed and Mental Hygid Is marked other sumatic event, II	To Be	Sylvester Grub	•					_		ve Kow		,	
Mar	2 2 20 20		19a. Informant's Name/Relationship Diana Stillwell								il Route Numbe			
Baltimore,	Pages 1 and 2 nent of Health int: If Item 27 iry or other tru		20a. Method of Disposition 1 Burial 2 Cremation 3 [4 Donation 5 Other (Speci	Removal from Sta	20b. Place	ery, crema	tion (Name atory or oth	e of er place)	D	t Mill Date 1-06		20634 cation - City or dalk , M	
Balti	permit. Pag Department Important: any Injury o		21. Signature of Funeral Service Lice	Maria	A	22.1	Name and	Address East	of Facility tern	Wes Ave	sley C e. Bal	hav:	is,Jr.	FH
	Physician /Medical		23a. Part : Enter the disease of conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each	id the death. Do	1	halo	. 1)	cardiac o	or respiratory ar	rrest,		Approximate Interval Between Onset and Death
8760,	ate be executed hysician and burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. He	as a consequence	C	TV .							
.O. Box 6	that the death certifice ed by the attending ph detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		2 Fetal deat at time of death		ctopic pred					2	3d. Date of de Month	ivery Day Year
rds, P.	faw requires that as been signed t 2 should be deta	by	Part II. Other significant conditions	contributing to death	but not resulting	in the und	lerlying cau	use giver	n in Part I.				se contribute to	the cause of death?
Division of Vital Records,	The la	Completed									24a. Was autop perfor 1 \(\text{Yes} \)		24b. Were at prior to death?	itopsy findings available completion of cause of 2 No
f Vit	d is	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	itient 2 ER/C	Outpatient	3□ DOA	Other	•		(Check only one 5 ☐ Resid		☐Other (Spe	cifv)
sion o	ding h. After fune	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		njury 28b. Day Year)	Time of Injury	M 280	injury a Work?		2	28d. Describe h			
Divi	itel or Atten irs after deati al Director: led in by the	Certifi	4 Homicide determined	building,	njury - At home, i etc. <i>(Specify)</i>						City or Tow	m, State)		ural Route Number,
	the Hospitel hin 24 hours a the Funeral upletely filled	Medicai	one)	hysician: To the beaminer: On the basis and manner	of examination a	ge, death o and/or inves	stigation, ir	n my opii	nion, deati	d place, a h occurre	and due to the dead at the time, o	cause(s) date and	and manner as place, and due	stated. to the cause(s)
)	To I Som	W	29b. Signature and little of certifier Leony C 30. Name and address of person who	Wil	SIM 1	7.D.	29c.	License (Number 136	5	r	lave	signed (Mont	7. Day, Year) 2016
4	1					900 Pr	Lock	Re	aven	Boi	nlevard) B	attimr	r, MD. 21218
	Sta Registr		31. Date filed (Morlth, Day, Year) MAR 2. 0 2	2006	strar's Signature	L	30							

William Pau 06-01677	1 (Griffin, Jr. Please T	ype or Print in E			_	_	ble.		
crn		1 - For State Registrar	State of Marylan	•	ent of Health and atte of Death		giene () (Reg. No.)6	083	24
Physic /Medi Exami	cal	Decedent's Name (First, Middle, Last) \times I A M 4a. Facility Name (If not institution, give s	PAUL treet and number)	GRIFF.	IN TR,	2. Date of Dea Month March	Oay O8 4c. County		3. Time of 0 1:20	Рм
Funeral	lei	1027 Cathedral Str	reet, Apartmer		altimore der 1 Year If Under 24 Hrs s Days Hours Min		h	Coun		
Director • • • • • • • • • • • • • • • • • • •	or	Usual Residence of Decedent 10a. State 10b. County	9	y, Town or Location	BALTIMORE	MAYO	1,1972 -1/		Od. Inside City	y Limits
Jeath with the A me 23a or 28a-1 rrust be notifi	Funeral Director	10e. Street and Number 1027 N, CAT 11. Marital Status	HEDRAL ST. 2. Was Decedent Ever in U	APTIID	Zip Code 2/2 cedent of Hispanic Origin? (5	Specify Yes or No-		SA,	an Indian,	
21215-0036 d within 72 hours after or giene. or than "natural", or iter the Mcdical Examine.	b	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes	pecify Cuban, Mexican, Puèi 2. No Specify: sual Occupation		Specifi 16b. Kind of B	134	ACK	
d 21215 filed within 7: Hygiene. sther then "n ent, the Med	e Completed	(Specify only highest grade Elementary/Secondary (0·12) THERADE 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	11	work done during most of wo use retired) EKEPIN 18. Mother's Na		JANITO Maiden Suman		SERV	lices
Maryland d 2 should be file tht and Mental Hy Z7 is marked othe	To Be	19a. Informant's Name/Relationship (Type	pe, Print)	19b. Mailing Addre	MIL.	DRED Jural Route Number	or, City or Town,			1018
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if itsm 27 is marked other than "natural", or items 23a or 28a-f show eny highry or other traumatic event, the Medical Examiner must be notified at opines.		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature Fun ral Service Li ans	emoval from State	Place of Disposition (Nonetary, crematory of NG MEM 22, Name	or other place)	Date AVE.	BALTO BALTO	City or To		
Physician /Medical Examiner		23a. Part1. Enter the disease, or compile shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the deat e cause on each line. HYPEQTENS Due to (or as a conseq	h. Do not enter the m	ode of dying, such as cardia	ic or respiratory ar	rest,		Approximate Interval Betw Onset and D	veen
Cords, P.O. Box 68760, requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)							
Records, P.O. Box 68760 The law requires that the death certificate be e te has been signed by the attending physicien age 2 should be detached for use as the burit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	al death 3 Ectopic				te of delive	•	'ear
rds, P.		Part II. Other significant conditions con	tributing to death but not res	sulting in the underlyin	g cause given in Part I.		obacco use con res 2 🗆 No		e cause of de	
Re(The lavate has	Completed					1 X Yes	rmed? 2 □ No	Were autopprior to condeath?	osy lindings a npletion of ca 2 No	ivailable iuse of
of Vital Physician: r this certifica	To Be	25. Was case relerred to medical examiner? 1 X Yes 2 □ No	ospital: 1 Inpatient 2	ER/Outpatient 3		eath <i>(Check only o</i> Home 5 \subseteq Resid		ner (Specify	at sce	ene
Vision of Attending Phy r death. ector: Atter thi by the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe h	now injury occur	red		
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Medical Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fac	tory, office	28I. Location (S City or Tox		ber or Rura	i Route Numi	⊅9 <i>r</i> ,
Hospitai 24 hours a 5 Funerai I	dicai	29a. Certifier (Check only one) 1 Certifying Physical Examination	ician: To the best of my knoner: On the basis of examinating and manner stated.	owledge, death occurr ation and/or investigat	ed at the time, date and plaction, in my opinion, death occ	e, and due to the curred at the time,	cause(s) and m date and place,	anner as st and due to	ated. the cause(s)	i
To the within 2 To the comple	Me	29b. Signature and title of certifier	3.3.3		29c. License number		29d. Date signe			
		30. Name and address of person who co	mpleted cause of death (Iter	m 23a) (Type, Print)	O.C.M.E.		March 09			
		AMA RUE 31. Date filed (Month, Day, Year)		111 Penn	Street, Balt	imore, Ma	aryland	2120	L 	
S Regis	tate trar	MAD 9 0 20		K Lock	9					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 3-50 AM GRUND 2006 JOHN 03 18 /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A GOOD SAMA RITAN BALTIMORE HUSPITAL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Dec. 25, 1926 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1√ M 2□ F 79 Yrs. Maryland 217-20-3504 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f ahow item 27 is marked other then "natural", or items 23a or 28a-f above other traumatic event, the Medical Expression must be notified as 1X Yes 2 No N/A Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 4907 Greencrest Road U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1√Yes 2 No IYYes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Maryland 21215-0036 Yes, Give Year or Dates: 1 ☐ Yes 2√ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) BG &E Warehouse Foreman 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be should be f and Mental h 2 Raymond Grund Marie Schultheis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 st ment of Health and tant: if item 27 is 1 4907 Greencrest Road Baltimore, Maryland 21206 Mrs. Eileen Grund- Wife Baltimore, I 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State

4 ☐ Donation

5 ☐ Other (Specify) permit. Page Department of Important: If any injury or Hilltop Service Corp. 3/20/06 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Heather Cain Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 tentre 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** HEMORRHAGIC STROKE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in inediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto for sslainonsequence of Examine burial-transit Due to (or as a consequence of) attending physician for use as the buria Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ned by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, ate has been signi page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? certificate 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Impatient Certification: To 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) ŧ To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 MD RES 000 3.18.2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMAPITAN HOSPITAL I BALTIMORE KUMAR SUJEE 4000 31. Date filed (Month) State Registrar

State of Maryland / Department of Health and Mental Hygiene UU 6 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** DOROTHY /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE Johns Hopkins Bayview Care Center If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Jan. 23, 19 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 5. Social Security Number **Funeral** 1 □ M 2/CXF Mary Tand 219-01-9747 91 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Manyland 10a. State 10b County items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2√No Baltimore Dundalk Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 78 21222 Shipway Road United States Funeral death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married naturel', or Baltimore, Maryland 21215-0036 1 Yes No Specify: Specify: White ģ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 6th permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 Is marked other any injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Annie Hatfield Ernest Hall ္ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ernest Gosnell Son 21222 78 Shipway Road Dundalk, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Morgan Chapel Cemetery March 23, 2006 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory 1212 W. Old Liberty Road Winfield, MD Min Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death In medicine Cause (Final ise in or condition recting in death) RENAL FAILURE **Physician** ea /Medical Due to (or as a consequence of): **Examiner** CARCINOMA BLADDED ear UROTHELIAL Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examine or Attending Physician: The law requires that the death certificate be executed use as the burial-tran attending physicien and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760, Physiclan/Medical IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 4☐Pregnant at time of death 5 Other (specify) be detached Division of Vital Records, P.O. signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☑ Unknown 1 🗌 Yes 2 No Completed | 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1 Yes 2 No after death.

Director: After this certification by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death Check onl. one Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pending investigation 2 No 1 Tyes 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide To the Hospitel within 24 hours a 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 18, 106 D 57768 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baldmore MiDZIZZ Vicer (wel Hopkers 31. Date filed (Month, Day Year) 32 ₽egistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item # 23a,27,28a-f,pen/E,853,3/21/00 TI

	No.		1 - For State Registrar	State of Maryland			nt of He te of D			giene Reg. Nø.	you you you	08327
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Cynthia D. Ho	ouston					2. Date of De Month Februa	Day	20 2006	3. Time of Death 10:42 A ^M
	Examir		4a. Facility Name (If not institution, give s Prince George's Ho 5. Social Security Number 579-04-8592 6. Sec.	ospital Center)	Ch	everly erlyear	Location of Dea If Under 24 Hrs Hours Min	S. 8 Date of Bir	P ₁	County of Death Cince Geo 9. Birthp	orge's
	Director		Usual Residence of Decedent		115.				Feb. 2	3,196		ington, DC
	e Maryla Ba-f ehov	Director	MD Prince Ge		Town or Lo	cation				4		0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the 23a or 2	ral Dire	186 Greenmeadow Wa	ay #D			tip Code 0774				zen of What Coun ited Stat	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-1 ehow any Injury or other traumatic event, the Medical Examines must be traffied at ADGE.	Completed by Funeral	11. Marital Status Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates;			edent of His ecify Cuban 2 No	spanic Origin? (S n, Mexican, Puel Specify:	Specify Yes or No nto Rican, etc.))-	14. Race - Americ Black, White, Specify: Black	etc.
21215-0036	i within 72 ho jiene. r then "natur the Medical	ompleted	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed)	(Give	kind of v	use retired)	tion uring most of wo	orking	16b. Ki BO.	nd of Business/Inc Illing Al	ustry B.
Maryland 2	uld be filed Aental Hyg rked oths tic event,	To Be C	17. Father's Name (First, Middle, Last) Clifford Houston	- Palis				18. Mother's Na Katie	me (First, Middle Richards	, Maiden ON	Sumame)	
	and 2 should like the stand N 27 is made or trauma		19a. Informant's Name/Relationship (Typ. Nadene Houston	oe, Print) (Sister)					oural Route Numb		r Town, State, Zip 20020	Code)
Baltimore,	Pages 1: nent of He ant: If Item ary or oth		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State cen	-	natory or	ame of other place Ceme	·	Date /3/06		ntwood,	
Balt	permit. Departr Importe any inju		21. Signature of Funeral Service License	e e	22	Aust 3821	in Roy	yster Fi St. NW	neral H	ome ton,	DC 2001	1.
j.	Physician /Medical		23a. Part . Enter the disease, or complications shock, or head failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. e cause on each line. Anaphylactoid re Due to (or as a conseque	action		ode of dying	, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
58760,	cate be executed by sician and burial-transit can	edical Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque								
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3 🗆	Ectopic Other (pregnancy specify)			2	23d. Date of delive Month	ry Day Year
	w requires that been signed b should be deta	۾	Part II. Other significant conditions con	tributing to death but not resulti	ng in the un	nderlying	cause giver	n in Part I.		obacco u Yes 2[se contribute to th	,
Division of Vital Records,	: The law re cate has bee : page 2 sho	Completed							24a. Was auto perio 172 Yes	an osy omed? 2 \(\text{No}	prior to cor death?	osy findings available inpletion of cause of
<u> </u>	s certif	To Be	25. Was case referred to medicat examiner? 1 ▼xes 2 □ No	ospital: 1 ☐ Inpatient 2√12 EF	VOutpatient	• 3[][Other	~	ath (Check only o		5 ☐Other (Specify	a
و ر	ig Phy ter this neral o		27. Manner of Death		Bb. Time of Injury	. 30.	28c. Injury Work				y occurred Prol	
<u>0</u>	endin eath. or; Af he fur	atlc	1 Natural 5 Pending 2X Accident investigation	Feb. 20, 2006 Fr		A^{M}		es 2∭No			ion to pen	
DİX	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify) Residence	e, farm, stre	eet, facto	ory, office		28f. Location (City or To #D Largo	Street and wn, State, MD	d Number or Rura 186 Green	Meadow Way
	To the Hospital within 24 hours a To the Funerel completely filled	Medical	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my knowles: On the basis of examination and manner stated.	edge, death n and/or inv	occurre	d at the time on, in my opi	e, date and place inion, death occ	e, and due to the urred at the time,	cause(s) date and	and manner as st place, and due to	ated. the cause(s)
	within To th	Me	29b. Signature and title of certifier	C 22		2	9c. License	number		29d. Dat	e signed (Month, I	Day, Year)
)	- Kalen	*	Cabralla	× Hr			OCI	ME		Feb	ruary 21	, 2006
	Dor		30. Name and address of person who co	mpleted cause of death (Item 2	За) (Туре, І		1 Peni	n Street	. Baltim		Maryland	21.201
	Sta Bedistr		31. Date filed (Month, Day, Year)	Registrar's Signatur	· Aner	W						

			1 - For State Registrar	State of Ma	aryland		artment tificate			and M		Reg.(No.0 0	<u> </u>	08328
	Physici /Medic	al	Decedent's Name (First, Middle Samuel Muel Maca. Facility Name (If not institution)	Harris			4h City 3	Fown or	Location of	of Death	2. Date of De Month MM	Day	Year	3. Time of Death
	Examin	er	Northwest Hos				•		stown			Balt		
	Funeral Director		5. Social Security Number 215-52-0527		je (In yrs. las	st birthday) Yrs.	If Under Months	1 Year	If Under Hours		8. Date of Bird (Month, Da JULY	14,1916	9. Birthi Cou In	place (State or Foreign Intrv) ICLA
	and w		Usual Residence of Decedent 10a. State 10b. County	у		Town or Lo								10d. Inside City Limits
	Many	tor	MD Bal	Ltimore	Ca	atonsv	ville							1 ☐ Yes 2 No
	ith the	Director	10e. Street and Number				10f. Zip		1000			10g. Citizen of W United		•
	eath w	eral	7501 Ashton	Valley Way	Ever in U.S.	13 \	Was Deced		1228	ain? (Sne	city Yes or No			ican Indian,
36	filed within 72 hours after death with the Maryland Hygiene. Hygiene Hygiene then "natural", or Iteme 23s or 28s-(show ent, Ire Madical Examinar must be notified at	by Funeral	1 Never Married 2 Mail 3 Widowed 4 Divorce	Armed Forces?			fYes, spec		Specify:	i, Puerto i	ocify Yes or No Rican, etc.)	Specify:	, White,	
2	72 hou	sted		ent's Education est grade completed)		16a. Deced	lent's Usua kind of wor	1 Occupa	ition	t of worki	na	16b. Kind of Bus	iness/Ir	ndustry
9500-61212	within ne.	Completed	Elementary/Secondary (0-12)	College (1-4or :	5+)	life. L	DO NOT us	e retired)			Bethle	em S	Steel Co.
7 0	be filed v tat Hygie d other t event, In		17. Father's Name (First, Middle	5+ , Last)			Engin	eer	18. Mothe	er's Name	(First, Middle,	Maiden Sumame		70001
_	0 = 0 >	To Be		Harris						Esthe				
Mar	nd 2 sh lith and 27 le m r traum	n I	19a. Informant's Name/Relation Prem Harris	ship <i>(Type, Print)</i> Son							th Rd.	er, City or Town, S Upper M		p Code) 20772 poro, MD
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic e once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Dor/ation 5 ☐ Other (3)		Cer	ce of Dispo metery, cren SUTTE	sition (Nam	ne of ther place	9)	D	n 20, 20	20c. Location - (006 Bal	•	own, State ore, MD
Balti	permit. Departm Imports any inju		21. Signature of uneral Service	hicenses	'	Bui 12	Name and Tier-C	Addres Lieen Old	Funer Libert	al Hor v Roa	me & Oren d Winfie	matory, PA eld, Maryla	and	21784
			23a. Par 1. En er the disease, of shick, or heart failure. Lis	or complications that caused st only one cayse on each li	d the death. ine.									Approximate Interval Between Onset and Death
1	Medical		Immediate Couse (Final disease or condition resulting in death)	a./	PSIS									Onset and Death
	Examiner			Due to (or as	EU M									
	sit ad	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	One to (or as										
,760,	ate be executed hysician and he buriat-transit	cal Examiner	that initiated events resulting in death) Last	cDue to (or as	a conseque	ance of):								
89	tificate ng phy: as the			0.	-						-		, U	
	at the death certificat by the attending phy stached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal c	death 3	Ectopic pro Other (spe					23d. Date Mon		very Day Year
_	law requires that the as been signed by th 2 should be detache		Part II. Other significant condit	tions contributing to death be	out not result	ting in the u	nderlying ca	ause give	on in Part I				bute to t	the cause of death?
Vital Records,	sician: The law req centificate has beer irector, page 2 shou	Completed by	arguete, me	heart tou	per	tensi	Jon .					rmed?	eath?	opsy findings available ompletion of cause of
ita	ien:] rtifical	BeC	25. Was case referred to medica	al					26. Place	of Death	1 ☐ Yes ∩ (Check only o		☐ Yes	20 140
>	hysicie this cert al direct	၉	examiner? 1 ☐ Yes 2 ÎD No	Hospital: 1 Dhipatio		RVOutpatien			4 🗆 NU			dence 6 □Othe		ıfy)
0 0	Attending Physician: r death. sctor: After this certifics by the funeral director.	tlon:	27. Manner of Death 1 Natural 5 Pend	28a. Date of Inju ling (Month, Da stigation	iry Year) 2	28b. Time of Injury	M 2	8c. Injury Work	rat ⊲? Yes 2.∐		28d. Describe l	how injury occurre	d	
Division of	I or Attend after death Director: , d in by the f	Certification:	3 Suicide 6 Could	d not be 28e. Place of In	jury - At hon tc. (Specify)	ne, farm, str					28f. Location (: City or To		r or Rur	ral Route Number,
_	Hospita 4 hours Funeral	edical C	29a. Certifier 1 1 rtifyi (Check only one) 2 Medica	ring Physician: To the best	of examination	vledge, death on and/or in	n occurred a	at the tim	ne, date an pinion, dea	nd place, a	and due to the ed at the time,	cause(s) and mar date and place, a	iner as : nd due f	stated. to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifi		ated.		29c	. License	number			29d. Date signed	(Month.	. Day, Year)
	0		▶ RRa	ngenapy	MD			05	428	8		Man	ch	1814 2006
Ì	0		30 Name and address of person	ing I R	ange	arej	uz	M	sitty	vet	Holp	tal ca	ulg	18th 2006
14	Sta Registi		31. Date filed (Month, Day, Year MAR 2 0		rar's Signatu	Ire Scan	W							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 1 - For State Registrer Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** HOUSTON . 20 PM DELMA 2ccc MARCH /Medical 4a. Facility Name of not institution. 4c. County of Death dive street and number) 4b. City Town, or Location of Death **Examiner** more If Under 1 Year If Under 24 Hrs. 8. Date of 9. Birthplace (State or Foreign Age (In vrs. last birthday al Security Number **Funeral** Months Days Hours 1 □ M 2 12 Director Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Deperment of Heelih and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ "" any highy or other traumatic average. 10d. Inside City Limits 10c. City, Town or Location HIMOre 1 Yes 2 No Completed by Funeral Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 7 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementa y/S extop ary (0-12) College (1-4or 5+) omemai (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mather's Name Be 1710. ueen irence Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Fundral Service Licensee Part I. Enter the disease, or complications that caused the death. Do not enter the mode of trying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Intarc bable Physician Myocardi minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner years inbetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) years use as the burial-transit or Attending Physicism: The law requires that the death certificate be executed Cancer e VI a that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 Days
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification: To Be Completed by 3 ☐ Probably 4 DUnknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient PR/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes X No 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of eath 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No r death. investigation within 24 hours efter death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by Hospitel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Fune completely f (Check only one) 29b. Signature and title of certifier D.O. asic 0055662 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hanover South 3001 31. Date filed (Month, Day, Year) . Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAR 2 0 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician Jackson March Ĩ'5 2006 1:10a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care Nursing Home Towson Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, 05 04 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1□M 2 F Months 82 Yrs. 254-26-9969 Director GÁ Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or itema 23a or 28a-f show adical Examiner must be notified at 1 XYes 2 ☐ No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iges 1 and 2 should be filed within 72 hours after death with nt of Health and Mental Hygiene. If Item 27 is marked other than "natural; or Itema 23a or; or other treumatic event, the Medical Examinating must be no or other treumatic. 21215 4017 Cedardale Road U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Supply Ch 12th grade Bookkeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mattie Croxton Jim Dismuke 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jory Campbell-Daughter Cedardale Road, Balto, Md Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
importent: if itel
any injury or oth 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 □ Ponation 5 □ Other (Specify) Metro Crematory Inc. 3/20/06 Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear valure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician -EREBROVASCULAR disease or condition resulting in death) /Medical Due to (or as a consequence of) Months Examiner STrek. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed sician and burial-trans resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has t lirector, page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 10 2 ER/Outpatient 3 DOA Director: After th 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: or Attending Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 3 🗀 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a To the Funerel L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title 2-0012849 Ello 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER Dr. TONSON MD H-6-412.70 7600 3 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 0 2006 Bolus Registrar

Dhuciaia		- State Registrar Amend Ite 1. Decedent's Name (First, Middle,	Last)	rn G	072 9Y	214 10000			Reg. 2. Date of Death		3. Time of Death
Physicia /Medic		Chester		Ernes	t	J	acks	on	March	17. 2000	2328 M
Examine		4a. Facility Name (If not institution,						cation of Death		4c. County of De	ath
		St. Hanes F	tealthe	CIRE		Bal	timo	ORE		17 1010	
Funeral		5. Social Security Number 219-01-9120	6. Sex 7 XXM 2 ☐ F	'. Age (<i>In yr</i> s. - 85	88 Yrs.	Months 1		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	-1/-19 bg	irthplace (State or Foreign Country) MD
Director		Usual Residence of Decedent		-05	00				01 17	2.1	HD
1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. tem 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Madical Examinar man be notified at		10a. State 10b. County		10c. C	ty, Town or Lo	ocation					10d. Inside City Limits
Mar Hied	햣	MD NA		B	altim	ore					1X Yes 2 ☐ No
or 28	Director	10e. Street and Number				10f. Zip C	Code		10g.	. Citizen of What 0	Country?
23a		3228 Gwynns F	alls Pkw	У			212	216		U.S.	A •
in the man	Funeral	11. Marital Status	12. Was Deced	ces?	J.S. 13.	Was Decede If Yes, specif	int of Hispa by Cuban, N	anic Origin? (Sp Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - Am Black, Wh	nencan Indian, nite, etc.
ig i	by F	1 Never Married 2 Marrie 3 Widowed 4 Divorced	d 1X1Yes 2 If Yes, Give Year or Da	9		1 □ Yes 🎖	XNo S	Specify:		Specify:	Black
I E	ed	15. Decedent's		165.	16a Dece	dent's Usual	Occupation	n	161	b. Kind of Busines	
2 4	Completed	(Specify only highest	grade completed) College (1-	45-)	(Give	kind of work DO NOT use	done durir retired)	ng most of work	king		
eg .	E	12th grade	na	40(5+)		Chauf	feur	7	A	rundel	Corp.
vent,	Bec	17. Father's Name (First, Middle, L	ast)				18	. Mother's Nam	ne (First, Middle, Mai	iden Sumame)	
rked tic e	2	Albert Jackson	n				M.	lary Cl	hismon		
aum aum		19a. Informant's Name/Relationshi	ip (Type, Print)						ral Route Number, C		
i Haatin and Mental Hyglene. Item 27 is marked other than "natural", or Items 23a or 28a-1 ehow other traumatic event, the Micdical Exeminer must be motified at		Clementine Ja	ckson-Wi					alls 1			, Md 21216
r oth		20a. Method of Disposition 1 Disposition 2 □ Cremation	3 □Removal from S	tate 20b.	Place of Dispo cemetery, cre	osition (Name matory or oth	e of ner place)			c. Location - City o	
lury (4 □ Donation 5 □ Other (Sp.	ecify)	Cr	ownsv			3/24	/06 Cr	ownsvil	le, Md
Important: if item 21 any injury or other tones.		21. Signature of Funeral Service L	5 Xek	2	M 4	2 Name and arch 300 W	Address o F/H Vabas	West h Ave	, Baltim	ore, Mo	21215
		23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that cannot one cause on ea	used the dea	th. Do not en	ter the mode	of dying, s	uch as cardiac	or respiratory arrest		Approximate Interval Between
ysician		Immediate Cause (Final disease or condition	Ac	to a	yocar	-dial	infar	ction			Onset and Death
Medical		resulting in death)	Due to (c	or as a conse		c i d i	<i>11</i> 1141	C) LUII.			7 ne cir
aminer	_	Sequentially list conditions,			nsion						15 years
sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Du ti (c	or as a c ^o nse	quence of):						`
physicien and the burial-transit	хап	that initiated events resulting in death) Last	c. Due to (c	or as a conse	quence of);						
buria	dica) E										
s the	edic		0.								
attending pr	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc							23d. Date of d	elivery
hed for	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregna	th 2□Fet int at time of		⊒Ectopic pred ☐ Other <i>(spe</i> d				Month	Day Year
detached	Physician/Med	9 Unknown	9□ Unknov	wn							
	D P	Part II. Other significant condition	s contributing to dea	ath but not re	sulting in the u	ınderlying caı	use given ir	n Part I.	23e. Did tobac	co use contribute	to the cause of death?
									1 🗆 Yes	2 □ No 3 🕰	Probably 4 ☐Unknown
has been pe 2 shou	ompieted								24a. Was an autopsy	24b. Were	autopsy findings available o completion of cause of
director, page	S								performed	d? death?	es 2 No
certificete rector, pag	Be	25. Was case referred to medical examiner?					26	6. Place of Dea	th (Check only one)		
	္	1 ☐ Yes 2 € No	Hospital: 1 ☐ In	patient 2	LER/Outpatie	nt 3 DOA	Other:	4 Nursing H	ome 5 Residenc	e 6 Other (Sp	pecify)
		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of (Month	Injury , Day Year)	28b. Time o	1 28	c. Injury at Work?		28d. Describe how	injury occurred	
fter th	0	2 ☐ Accident investiga	ition			М	1 🗌 Yes	2 🗆 No		A.MI	
	catio			of Injury - At h g, etc. <i>(Sp</i> eci	nome, farm, st fy)	reet, factory,	office		28f. Location (Stree City or Town, S	et and Number or i State)	Rural Route Number,
tor: After t	rtificatio	3 Suicide 6 Could no 4 Homicide determin	buildin	3				1			
tor: After t	cai Certification;	4 Homicide determine 29a. Certifier 1 Certifying	Physician: To the	pest of my kn	owledge, deat	h occurred at	t the time,	date and place,	, and due to the caus	se(s) and manner	as stated.
taly filled in by the funera		4 Homicide determing the determing determing the determing the determing the determing determing the determination of the deter	Physician: To the	pest of my kn	owledge, deat ation and/or in	vestigation, i	n my opini	on, death occur	rred at the time, date	and place, and de	ue to the cause(s)
tely filled in by the funera	Medical Certificatio	4 Homicide determing the determing determing the determing determing the determing determine the determine determine the determine determine the determine determine the determine determine the determine determine the determine	Physician: To the laxaminer: On the bar	pest of my kn	owledge, deat ation and/or in	vestigation, i	t the time, on my opinion	on, death occur	rred at the time, date	se(s) and manner of and place, and di	ue to the cause(s)
tely filled in by the funera		4 Homicide determing the determing determing the determing the determing the determing determing the determination of the deter	Physician: To the laxaminer: On the bar	pest of my kn sis of exa <i>m</i> in er stated.	ation and/or in	29c.	n my opinio	on, death occur umber	rred at the time, date	and place, and de	nth, Day, Year)
death. tor: After t the fu∩era		4 Homicide determing the determing determing the determing the determing the determing determing the determination of the deter	Physician: To the barantees: On the barantees and manni	pest of my kn sis of exa <i>m</i> in er stated.	ation and/or in	29c.	n my opinio	on, death occur umber	rred at the time, date	and place, and de	nth, Day, Year)

Control Control Control Control Control			Unpend item# 23	a, 37, 28a-f M	TVE-8855-5-5	artment of H	Health and	Mental H	vaiene	c 000°	29
Descends themselfore, Action,			T_ State		Ce	rtificate of	Death		Local Control	0 000	16
Benjamin Name Country Countr				ist)					eath	3. Time of	f Death
# Facility Name of Total American (not served and number) # For Part 1908			Benjamin	N.	Jo	nes					D N
Social Security Number 2 Social Security Number 2 Securi			4a. Facility Name (If not institution, given	re street and number)		4b. City, Town, o	r Location of Dea				
Social Security Number 2 Social Security Number 2 Securi			11908 Tarragon R	oad Apt.	I	Reister	stown		Balti	imore	
Description of Desc	Funera	l	5. Social Security Number 6. 5	Sex 7. Age					irth		or Foreig
The Same 100, Covery 100, Chip Yorn or Location 100	Directo		213-00-0724	X-111 2 2 1	ZZ, Yrs.			December	r 15,1983	Maryland	
The second of the property of	end we				10c. City, Town or Lo	ocation				10d. Inside C	ity Limit
The second of the property of	Mary l	ō	Maryland Baltimo	re	Reister	stown				1 □Yes	2 X N
The second of the property of	28a	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?	
The second of the property of	3a or	O	438 Main Street			2113	36		USA		
23a. Part. Enter the disease for complications that caused the debth. Do not enter the mode of dying, such as cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause of cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory ar	deatl	ner	11. Marital Status		Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Specify Yes or N	lo- 14. Ra		
23a. Part. Enter the disease for complications that caused the debth. Do not enter the mode of dying, such as cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause of cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory ar	or its	F	1 Never Married 2 Married		lo			into nican, etc.)			
23a. Part. Enter the disease for complications that caused the debth. Do not enter the mode of dying, such as cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause of cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory ar	Jours Jours	d b	3 Widowed 4 Divorced	Year or Dates:		10100 202010	Specify.		Specia	y. White	
23a. Part. Enter the disease for complications that caused the debth. Do not enter the mode of dying, such as cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause of cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory ar	72 h	ete			(Give	kind of work done	during most of w	orking	16b. Kind of B	Business/Industry	
23a. Part. Enter the disease for complications that caused the debth. Do not enter the mode of dying, such as cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause of cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory ar	withir	m d		College (1-4or 5	+)		a)		Color		
23a. Part. Enter the disease for complications that caused the debth. Do not enter the mode of dying, such as cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause of cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory ar	Hygied ther	ပိ)	Sal	esman	18. Mother's N	ame (First, Middl	1		-
23a. Part. Enter the disease for complications that caused the debth. Do not enter the mode of dying, such as cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause of cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory ar	d be			,					o, maioon coma	,,,,,	
23a. Part. Enter the disease for complications that caused the debth. Do not enter the mode of dying, such as cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause of cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory ar	Shouls and Me	F		Type, Print)	19b. Maili	ng Address (Street			ber. City or Town	. State. Zip Code)	
23a. Part. Enter the disease for complications that caused the debth. Do not enter the mode of dying, such as cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause of cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory ar	ING 2 in the arriver	1	Eric Epstein	Friend		-					
23a. Part. Enter the disease for complications that caused the debth. Do not enter the mode of dying, such as cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause of cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory ar	S 1 a		·		20b. Place of Dispo	osition (Name of	Ma Ma	rch 20	20c. Location	- City or Town, State	
23a. Part. Enter the disease for complications that caused the debth. Do not enter the mode of dying, such as cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause of cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory ar	Page Bent o Int: If				Bayview C	rematory	2	006	Baltimo	ore City, M	D.
23a. Part. Enter the disease for complications that caused the debth. Do not enter the mode of dying, such as cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause (main fine) and such as a cardiac or respiratory arrest, introduced cause of cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, introduced cause or death interview and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory arrest, and such as a cardiac or respiratory ar	mit.				20 2	2. Name and Addre	ss of Facility	Homo Of	Dundalle	D 7	
23. Part I. Enter the disease for complications that caused the default. Do not enter the mode of dying, such as cardiac or respiratory arrest, inference above on each time. Approximate Cause (Final resulting in death) Immediate Cause (Final resulting in death) Sequentially let conditions Sequentially let conditions Sequentially let conditions Due to (or as a consequence of): Due to (or as a consequence of): d Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a cons			Enthony	Conne	lly 7	110 Solle	ers Poin	t Road,	Dundalk	MD. 21222	
Methodo intoxication Due to (or as a consequence of):			23a. Part1. Enter the disease or com	plications that caused						Approximat	ie ween
Part Detect Det	Physician		Immediate Cause (Final								
Due to [or as a consequence of]: Due to [or as a consequence of]:	/Medica		resulting in death)								
Due to (or as a consequence of): The FEMALE 23d. Was decoded pregnant in the past 12 months? 1	Examine		Sequentially list conditions	b							
Due to (or as a consequence of): The FEMALE 23d. Was decoded pregnant in the past 12 months? 1	ים פ	Iner	Tary leading to knowledges cause. Enter Underlying	Due to (or as a	consequence of).					-	
State Part	ecute and trans	cam	that initiated events	c							
FEMALE: 23c. It yes, outcome of pregnancy 1Clive birth 2 23c. It yes, outcome of pregnancy 1clive birth 2 23c. It yes, outcome of pregnancy 1clive birth 2 23c. It yes, outcome of pregnancy 1clive birth 2 23c. It yes, outcome of pregnancy 1clive birth 2 23c. It yes, outcome of pregnancy 1clive birth 2 23c. It yes, outcome of pregnancy 1clive birth 2 23c. It yes, outcome of pregnancy 1clive birth 2 23c. It yes, outcome o	cate be ex chysicien a	E		Due to (or as a	a consequence or):						
State Stat	cate physi	dig		d							
State Stat	Se as	/We		23c If yes outcome	of pregnancy			==	00.10		
State Stat	Both cert attendin for use	cian	in the past 12 months?	1 Live birth	2 Fetal death 3		1				Year
State Stat	her the d d by the letached	issi			35						
State Stat	thet thet hed b	Į d	Part II, Dther significant conditions	contributing to death bu	at not resulting in the u	inderlying cause giv	ren in Part I.	23e. Did	tobacco use con	tribute to the cause of o	death?
State Stat	duires n sign	q p						1	Yes 2 □ No	3 □ Probably 4	Jnknown
State Stat	S s s s s s s s s s s s s s s s s s s s	lete						24a. Wa	s an 24b.	Were autopsy findings	available
State Stat	The la	E G						per	opsy formed?	prior to completion of c death?	ause of
State Stat	en:] tifice for. p	O					26 Place of D			Yes 2LINO	
State Stat	ysici is cer direc	0 8		Hospital: 1 ☐ Inpatier	nt 2 ER/Outpatier	nt 3 DOA Oth				ner (Specify) SCAN	0
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and due to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pamela E. Southail, Ma. 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Fer th	l':u	27. Manner of Death	28a. Date of Injur							
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and due to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pamela E. Southail, Ma. 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ath.	atic	2 Accident investigatio	Fnd 3/15/2				unk			
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and due to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pamela E. Southail, Ma. 31. Date filed (Month, Day, Year) 32. Registrar's Signature	JIVISION I or Attending after death. Director: Afte	tific	determined	289. Place of Inju	ry - At home, farm, str. (Specify)	reet, factory, office		28f. Location City or To	(Street and Numi	ber or Rural Route Num	iber,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Panela E. Southail, rai) State 31. Date filed (Month, Day, Year) 32. Registrar's Signature March 16, 2006 March 16, 2006 March 16, 2006	itai o irs afti ied ir			house				Keisters	town, MD		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Panela E. Southail, rai) State 31. Date filed (Month, Day, Year) 32. Registrar's Signature March 16, 2006 March 16, 2006 March 16, 2006	Hosp 4 hou Fune ely fil	cai	(Check only 2 XMedical Exal	nysician: To the best on miner: On the basis of	of my knowledge, deat examination and/or in	h occurred at the tir	ne, date and place	e, and due to the	e cause(s) and m	anner as stated. and due to the cause(s	;)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Panela E. Southail, rai) State 31. Date filed (Month, Day, Year) 32. Registrar's Signature March 16, 2006 March 16, 2006 March 16, 2006	the hin 2 the I	Jed	one)	and manner sta	ted.					/	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pamela E. Southail, Mil 111 Penn Street, Baltimore, Maryland 21201 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	To To	-	250. Signature and title of certifier	11 . 1 . 1		29c. Licens	19Onun e		∠9a. Date signe	ed (Month, Dey, Year)	
Pamela E. Southail, Mi 111 Penn Street, Baltimore, Maryland 21201 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	70		Yanda Tull	may, mis					March 16	5, 2006	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	U		D 1 - 1	1.2	eath (Item 23a) (Type,		Ctroct	B-1+	oro Me-	arland 212	Ω1
State		ato			r's Signature	III Penr	r street	, Dartin	ore, mai	yranu 212	OT.
				<i>M</i> .	-	ark.					

		_	For State Registrar		State of	Marylar			nt of Hotel				Reg. No	211116)	08333
	Physici /Medio			exander		kevich		45 03	-		M	2. Date of D Month arch	15 ^{Da}	^{1y} 2006°		3. Time of Death 3:40 p M
,	Examin	ner	4a. Facility Name (If not ins	_		oer)			timor	Location of	Death		40	:. County of D	eatn	
	Funeral Director		5. Social Security Number 227-37-0031 Usual Residence of Deced		M 2□F	Age (In yrs. 27	last birthday) Yrs.	If Unde Months	Days	If Under 2 Hours	Min.	8. Date of B (Month, D OCT 23	irth Day, Year 197	9.	Birthpl Coun	ace (State or Foreign ry) VA
	a-f ahow	tor		County N/A			y, Town or Lo								10	0d. Inside City Limits 1 X Yes 2 ☐ No
	a or 28	Funeral Director	10e. Street and Number 3107 Mareco	Aronus	2			10f. Z	Code 212	13			10g. Ci	tizen of What		ry?
1	ma 23	neral	11. Marital Status		2. Was Decede	ent Ever in U	.S. 13. \	Was Dece			in? (Spe	cify Yes or N	10-	14. Race - A	Americ	
999	ural, or ite	by	1X Never Married 2[3 ☐ Widowed 4 ☐ Dir	vorced	1 ☐ Yes 2 If Yes, Give Year or Date	K] No		1 🗆 Yes	2 🔀 No	Specify:	, ruento r	110a11, 9(6.)		Black, V Specify:		white
-6121	within 72 in the metalical	Completed		cedent's Educ highest grade 0-12)		or 5+)	16a. Deced (Give life. L	kind of w DO NOT	ork done d ise retired)	uring most	of working	ng		Gind of Busine $-{ m lectic}$		ustry
ylalid	is 1 and 2 should be lied within 72 hours aller death with the maryland. If Health and Mental Hygiene. Item 27 is marked other than "natural", or Itema 23a or 28a-f ahow other traumatic avant, the Madical Examinar must be notified at	To Be C	17. Father's Name (First, A. Robert S		skevich							(First, Middl Rap		n Surname)		-
Mar	Ith and 27 is my		19a. Informant's Name/Re Robert S. J	, , , , ,		ther						Route Num.		or Town, Star	te, <i>Zip</i> 3 13 (
ָּהָ ס	permit. Pages 1 and 2 Department of Health a Important: If Itam 27 is any injury or other tra once.		20a. Method of Disposition 1 ☐ Burial 2 🛣 Crem			20b. F	Place of Dispo cemetery, cren	sition (Na natory or	me of other place	9)	D	ate	20c. L	ocation - City	or To	wn, State
	artment ortant: injury o		4 ☐ Donation 5 ☐ Of 21. Signature of Funeral S	ther (Specify)		Che	esapeak								e,	MD
ă	Depa Impo		15- th	hill	-		1986 8	717	Green	rast	ures		e, To	wson,	MD	21286
	hysician /Medical Examiner		23a. Par11. Enter the dise shock, or heart failur. Immediate Cause (Final disease or condition resulting in death)	ase, or complice. List only one	And	th line.	stic					to m			į	Approximate Intervat Between Onset and Death YEAR
	ned Insit	mlner	Sequentially list conditions it any, leading to immediat cause. Enter Underlying Cause (Disease or injury	b.	Due to (or	as a conseq	juence of).								T	
5	ysicien and	cal Examiner	that initiated events resulting in death) Last	d.	Due to (or	as a conseq	guence of):									
O. BOX 00	the hospited or twinding registered. The law equites that the death centificate be executed in 24 hours after death. 1.24 hours after death. the Funeral bractor: After this certificate has been signed by the attending physicien and pletely filled in by the funeral director, page 2 should be detached for use as the buriat-transit.	Physician/Med	IF FEMALE: 23b. Was decedent pregning the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	arit		h 2 ∏Feta ntattime of d	ıl death 3 □	Ectopic p	regnancy pecify)					23d. Date of Month		y Day Year
CO,	n signed build be deta	۵	Part II. Other significant c	onditions conf	tributing to deal	th but not res	ulting in the ur	nderlying	cause give	n in Part I.				,		e cause of death?
וחשביו ופ	certificete has been si rector, page 2 should l	Completed									_	24a. Wa autr per 1 \(\text{Yes}	opsy formed?	prior	to con	sy findings available apletion of cause of
X	yarcısı is certif directo	To Be	25. Was case referred to n examiner? 1 Yes 2 No	_	ospital:	patient 2	ER/Outpatien	it 3□ D	OA Othe			Check only		6 □Other (5	Specify)
	uth. :: After this certific e funeral director.			Pending investigation	28a. Date of (Month,	Injury <i>Day Year)</i>	28b. Time of Injury	м	28c. Injury Work 1 🔲 Y	at ? ′es 2□N		8d. Describe	how inju	iry occurred		
SIA	to the mospine of extending within 24 hours after death. To the Europeal Director after Completely filled in by the funer	Certification:		Could not be determined	28e. Place of building	Injury · At h , etc. (Specil	ome, farm, stre	eet, facto	y, office		2	8f. Location City or To	(Street a. own, Stat	nd Number o e)	r Rurai	Route Number,
	24 hour 25 hour Funer stely fills	edical (29a. Certifier 1 Co (Check only 2 I Mil one)	ertifying Phys edical Examin	er: On the base and manne	is of examina	owledge, death	occurred vestigation	at the tim	e, date and inion, deat	d place, a h occurre	nd due to the	e cause(s , date an) and manne d place, and	r as sta due to	ated. the cause(s)
,	within To th	Me	29b. Signature and title of	certifier	~~»		SICIA	رم 29	c. License	number	10			ate signed (M		Pay, Year)
	JI		30. Name and so tress of p	person who cor		of death (Iter	n 23a) (Type,	Print)	(0°) 4	N	0-00	ADUA	~	1205		,
	Sta Registr		31. Date filed (Month, Day,	Year) 1 8 20	06 32. 109	gistrar's Signa	ature	and!		. ,, - ()						

DHMH 17 Rev 1/2001

3/15/00 0 3%

THOMAS ACEKANDER JUSKENICH

		1 - For State Registrar	State of Ma	ryland /				nd Mental	£	UU	5 "	0833	34
Physici	an	1. Decedent's Name (First, Middle, Las	t)							Day	Year	3. Time of	f Death
/Medic	cal	Lloyd Luke Kolbe	and and analysis			45 City Taylor	. Landina of	1======				6:45	A M
				d Livi	na		Location of	Death					
Discosoft Name (Prist Middle, Lats) Physician (Prist Middle, Lats) Lloyd, Lluke Kolbe Lat Archy have in Protection or incendency presented and number) Hart Heritage Estate Assisted Living Hart Heritage Estate Assisted		place (State o	or Foreign										
The project of the													
Thysician investigation with the properties of beautiful to th							1.	10d. Inside C	ity Limits				
Maryi f sho	tor	Maryland Harford	1	Str	eet								2√□No
n the	irec					10f. Zip Code			10g.	Citizen of W	hat Cou	ntry?	
Toward T			tes										
tems	nuel		Armed Forces?		13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origi n, Mexican,	in? (Specify Yes Puerto Rican, et	or No- c.)				
rs aft			If Yes, Give		1	☐ Yes 2 No	Specify:			Specify:	Whit	te	
2 hou		15. Decedent's Ed	ucation	168	a. Deced	ent's Usual Occupa	ation	, ,	16b	. Kind of Bu	siness/In	idustry	-
The Segistrar Ce Registrar Ce		lite. [NOT use retired	iuring most (')	ot working								
1 - Size Registrary 1 - Decedent's Name (First, Mickley, Last)													
od oth	00							,		len Sumami	3)		
December Name (Prox Mode), Last) Physician Alected Lloyd Luke Kolbe Last Lloyd Luke Kolbe Lloyd Luke Kolbe Last Lloyd Luke Kolbe Lloyd Lu		o Code)											
nd 2 salth ar 27 le													
item item		·		20b. Place	of Dispos	sition (Name of	e)	Date	20c.	Location -	City or To	own, State	
Page ment ent: Il ury o]	athe	edral Ceme	etery	3/17/200	06 Ba	altimo	re,	Maryla	and
ermit. epertungent nport ny Inj		21. Signature of Funeral Service Licen:	see		22	. Name and Addres	s of Facility	Hubbard	Fune	ral Ho	me,	Inc.	
2 205 4 9		230 Roda Fotor the disease or some	lications that as used t	he death De						re, Ma	ryla	and 212 Approximat	
		shock, or heart failure. List only of	one cause on each line).					ory arrest,			Interval Bet Onset and	tween
Description from the profits Manne (and profits Manne) (and profit			200	125									
Examiner				consequence	9 017.								
n =	ner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying		consequence	of):								
and trans	tami	that initiated events	c										
be ex icien a burial		rosuling in doubly cast	Due to (or as a	consequence	or):								
ficate phys s the	adic		d										
n certi	n/M									23d. Date	of deliv	өгу	
death	sicia	1 ☐ Yes 2 ☐ No	4 Pregnant at ti							Mon	th	Day '	Year
at the	Phy									j			
signed	ρ	Part II. Other significant conditions co	intributing to death but	not resulting	in the un	iderlying cause give	n in Part I.	23 e .					death?
v requ	etec							_	-				
he lav	mp								autopsy performed	2 0	eath?		available ause of
	40						26. Pface of			No 1			ed
nysicl	0		Hospital: 1 Inpatien	2 ER/0	utpatien	3 DOA Othe				6 Othe	r (Specil	W CAI	RE
ing Pt Mer th			28a. Date of Injury (Month, Day	Year) 28b.		28c. Injury Work	at	28d. Desc	cribe how in				
ttend death stor: /	icati	3 ☐ Suicide 6 ☐ Could not be	200 Place of laive	At home 4	form star		/es 2 □ No		ina (Pton at	and Month		10 11	
or A setter	ertif		building, etc.	(Specify)	arm, stre	ен, тастогу, опісе			or Town, St	and Numbe ate)	r or Hura	1/ Houte Num	iber,
spita nours neral		29a. Certifier Certifying Phy	sician: To the best of	my knowledg	ge, death	occurred at the tim	e, date and	place, and due to	o the cause	(s) and mar	ner as s	stated.	
he Ho in 24 he Fu pletel	edic	(Check only 2 Medical Exam	iner: On the basis of e	examination a	nd/or inv	estigation, in my op	pinion, death	occurred at the	time, date a	and place, a	nd due to	o the cause(s	i)
To t To t	Σ	1/2/	hen			7 7	Cas	, (41
		1211/1	n/2/1			D3	788	7	1	pach	14	, 200	26
5+1		30. Name and address of person who of AMARA SI	ompleted cause of dea	8/5	(Type, I	Print)	toil	rsel A	111	MO	21	1014	!
		EARD 9 0 2006	32. Hegistrar	s Smaature	1904								
		MARAULOUG											

		For State Registrar	State of M	Maryland / [artment <i>tificate</i>			and M	•	giene Reg. Nè.		/***	000	0.00
	-01	Decedent's Name (First, Middle, Last	st)							2. Date of De	ath	U U	0	3. Pime	of Dealth
Physici /Medic		Gerald Edward Koh	ler							Month March	13,		Year 006	8:30	A M
Examir		4a. Facility Name (If not institution, give	street and number	ar)				Location o	f Death				of Death		
18 1		228 E. Medwick Ga		A // / / / / / / /	46 -6- 3	Balti		e If Under 2	24 Uro	0.0 (0)	n/	a			
Funeral Director		Social Security Number 6. S 1	ex [X]M 2□ F	Age (In yrs. last bin	rnaay) Yrs.		Days	Hours	Min.	8. Date of Bir (Month, Da Sept 2	y, Year)	12	Cour	olace (State ntry) land	e or Foreign
D		Usual Residence of Decedent								sept 2	13.	12.	ricit y	Tana	
arylar ehow	_	10a. State 10b. County		10c. City, Town									1	10d. Inside	City Limits es 2 ☐ No
he M	Director	Maryland n/a 10e. Street and Number		Balt:	imo	re 10f. Zip	0-4-				10- 000				93 2 140
with	급	228 E. Medwick Ga	rth			212					10g. Citiz	_		-	
death ms 23	Funeral	11. Marital Status	12. Was Decede		13.	Was Decede	ent of His	spanic Orig	gin? (Spe	cify Yes or No		4. Race	- Americ	can Indian,	
or Ite	Ē	1 Never Married 2 Married	Armed Force 1 X Yes 2 [If Yes, Give		i	f Yes, speci		n, Mexican Specify:	i, Puerto I	Rican, etc.)			k, White,		
ural'.	d by	3 Widowed 4 Divorced	Year or Date			1 ☐ Yes 2						Specify:	Whi	.te 	
72 h	Completed	15. Decedent's Ed (Specify only highest gra		16a.	(Give	dent's Usual kind of worl DO NOT use	k done d	lurina most	t of workii	ng	16b. Kir	id of Bus	isiness/in	dustry	
212 I withi iene.	mo du	Elementary/Secondary (0-12)	College (1-4d		ine		0 / 01 0 0,	,			te	lep	hone	compa	anv
other	BeC	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle					
ary land 21215-0036 should be filed within 72 hours after death with the Maryland nd Mental Hyglene. s marked other than "natural", or Items 23s or 28e-1 show umailc event, the Madical Evertire mail be multilised at	ToE	Filmore Edward Ko	hler					Doro	thy	Anna Sl	himek	:			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 le marked other than "natural", or Items 23s or 28e-1 ehow any injury or other traumatic event, the Medical Examination and by notified at once.		19a. Informant's Name/Relationship (Kathleen M. Wilso:								<i>C</i> heste	-				-3625
altimore, mit. Pages 1 an partment of Hea portent: If item 3 y injury or other		20a. Method of Disposition		20b. Place of						ate				own, State	
Pages nent of nert of nut: If its		1 ☐ Burial 2 ∰ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		(U				1	3/20	/2006	Bali	timo	ore.	Marv]	land
Balti permit. Departin Importe		21. Signature of Funeral Service Licer	1500	1-4-7						bard Fi					
n 88558		> lynn kou			4	107 Wi	ilke	ns Av	enue	, Balt:	imore	, Mc	aryla	and 2	1229
Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	sed the death. Do not line.	lia			Dif			irrest,			Approxim Interval B Onset an	Between
Examiner	- G	Sequentially list conditions,	b. Due to (or	as a consequence	7 A	Nte	7	Dis	Cof	e					
ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Di	abetes	3	M	elli	tus							
18760, 26.	dical E		d	as a consequence	01).										
C 68	Med	IF FEMALE:													
vision of Vital Records, P.O. Box 6i Attending Physicien: The taw requires that the death certific r death. ector: Alter this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		2 Fetal death at time of death		Ectopic pre Other (spe					2	3d. Date Mon	e of deliventh	ery Day	Year
s that	by Ph	Part II. Other significant conditions of	ontributing to deat	n but not resulting in	n the u	nderlying ca	use give	n in Part I.		23e. Did 1	tobacco u	se contr	ibute to t	he cause o	of death?
cords, P w requires that s been signed t	ed b									10	Yes 2	ONC	3 Prot	ably 4 [Unknown
aw re	Completed									24a. Was		24b. V	Vere auto	psy finding	s available
The The ale has page	E O									auto perfo	ormed?	d	leath?	mpletion of 2 No	cause of
/ita	Be (25. Was case referred to medical examiner?						26. Place	of Death	(Check only	one)				
ohysi this c	၉	1 Yes 2 No		atient 2 ER/Ou				4 🗆 Nu		ne Resi				<i>y)</i>	
ding I	E G	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation			Time o	M 28	Bc. Injury Work	rat ⟨? Yes 2 ∐ !		28d. Describe	now injury	occurre	ed		
Division of Vital Records, to a standing Physicien: The taw requires the death. Director: After this certificate has been signed in by the funeral director, page 2 should be	Certification:	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of	Injury - At home, fa	ırm, str				-	28f. Location (er or Run	al Route No	umber,
Div ital or A rs efter ral Directled in by				etc. (Specify)						City or To					
Division of Vital Rec To the Hoepital or Attending Physicien: The law within 24 hours elter death. To the Funeral Director: Aller this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier Certifying Ph (Check only one) 2 Medical Exar	ysician: To the be niner: On the basis and manner	est of my knowledge s of examination an stated.	e, deat d/or in	n occurred a vestigation,	at the tim in my op	e, date an pinion, dea	d place, a th occurre	and due to the ed at the time,	cause(s) date and	and mar place, a	nner as s and due t	tated. o the cause	9(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier	1 . 5			29c.	License	number						Day, Year))
		194 ce	MD				05	051	7	-	3	115	706		
15+1		30. Name and address of person who	completed cause of	of death (Item 23a)	(Туре,	Print)		2 5	R	1 4 . 1	10	71-	1-0-		
		31. Date filed (Month, Day, Year)	, ,	strates Signature		7010	8 "	ريد	(Sa	VGD 10	- (1)	1)	18		
Sta	ite	11. Date filed (Month, Day, Year)	Ma S. Heg	Suran Signatura	42										

State of Maryland / Department of Health and Mental Hygiene

1	0	0	1	1
	1	J	J	1

1 _ For State

_	1130	1 1	U	1	U	1	. 3	. 1
	No	U	10	U	U	14	V	0

			Registrar		Ce	nificate of	Deam		Reg. No.		
	Physici /Medio		1. Decedent's Name (First, Middle, Last) ESSIE M. LA					2. Date of D Month March	Day	2006	3. Time of Death 3: 47 P M
	Examir	er &_	4a. Facility Name (If not institution, give s University of Maryla	nd Medical Ce		Baltim				unty of Death	
	Funeral Director		5. Social Security Number 6. Sex 214-44-6318	7. Age (In)	rrs. last birthday) 61 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		irth Day, Year) -44	9. Birthp Cour MD	place (State or Foreign htry)
	a-f ehow	ctor	10a. State 10b. County MD		City, Town or Lo Baltim					1	0d. Inside City Limits 1 Xes 2 No
	th with the 23a or 28	al Director	10e. Street and Number 1278 Kitmore Rd.			10f. Zip Code 21	239		10g. Citizen	of What Cour	ntry?
980	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Heath and Mental Hygiene. If item 27 is marked other than "naturel", or items 23a or 28a-f ehow or other traumatic event, the Modisal Exactly at marked profiled at	by Funeral	11. Marital Status 1 ↑ Never Married 2 ↑ Married 3 ↑ Widowed 4 ↑ Divorced	I2. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2/1/N o If Yes, Give Year or Dates:	n U.S. 13.	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 X No		Specify Yes or N rto Rican, etc.)	· · · · · · · · · · · · · · · · · · ·	Race - Americ Black, White, ecify: Bla	etc.
15-0	"natur	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retire	during most of we	orking	16b. Kind o	of Business/In	dustry
212	giene. grene. er than	Comp	Elementary/Secondary (0-12) 9th	College (1-4or 5+)		stodial	u)		Nurs	sing	
and	thould be filed withing Mental Hygiene. marked other than matic event, Ins.M.	Be	17. Father's Name (First, Middle, Last) William D.Lane					me (First, Middle ta Dos		name)	
Maryl	nd 2 should th and Men 27 is marke r traumatic	To	19a. Informant's Name/Relationship (Ty, Joy Lane	pe, Print)		ng Address (Street	and Number or F	lural Route Num	ber, City or To		Code)
Baltimore, Maryland 21215-0036	Pages 1 ar		20a. Method of Disposition 1 XBurial 2 Cremation 3 R 4 Donation 5 Other (Specify)		cemetery, cre	osition (Name of matory or other pla Cemete:	ry 3-2	Date 3-06		on - City or To	
Balti	permit. Pages. Department of H important: if ite eny injury or of		21. Signature of Funeral Service License	War A	2	2. Name and Address 007 WEa	ess of Facility W stern A	esley ve. Ba	Chavis lto.MI	s,Jr. D 2123	FH 31
100	Physician /Medical Examiner	Examiner	23a. Part. Enter the disede, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of):						Approximate Interval Between Onset and Death
.O. Box 68760,	that the death certificate be executed to by the attending physicien and detached for use as the buriat-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 mgnths? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pre 1 □Live birth 2 □f 4 □ Pregnant at time 9 □ Unknown	egnancy Fetal death 3	⊒Ectopic pregnanc □ Other (specify) _	у		23d.	Date of delive	ary Day Year
Ω.,	sigr d be	ρ	Part II. Other significant conditions cor	ntributing to death but not	resulting in the I	underlying cause gi	ven in Part I.	4	i tobacco use d		he cause of death?
I Records,	The ate h page	Completed						24a. Wa aut per 1 🗌 Yes	opsy formed?	prior to co death?	opsy findings available impletion of cause of
Vital	sician: certific rector,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:		0:	har	ath (Check only			
Division of	ding h. After fune	-	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpatie 28b. Time (Injury)	of 28c. Inju	4 🗀 Nursing	Home 5 Re	e how injury oc		(y)
Divis	ital or Attenirs after deat ral Director: led in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - / building, etc. (Sp	pecify)			City or T	own, State)		al Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in by	fedical	one)	sician: To the best of my ner: On the basis of exar and manner stated.	knowledge, dea nination and/or ii	nvestigation, in my	opinion, death occ	ee, and due to the curred at the time	e, date and pla	ice, and due to	o the cause(s)
	Twith	Σ	29b. Signature and title of certifier	*	m W	D PIG	1657		29d. Date si	igned (Month,	
	4		30. Name and address of person who or Susannah Batko-y	ompleted cause of death	(Item 23a) (Type 22 S.	Print)	st. Balt	more h	1D 217	201	

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** Jerry Lee Lilly-El 17:49PM 2006 MARCH 7 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAI HOSPITAL OF BALTIMORE BALTIMORE C
If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. 1**∑**M 2□F Days Hours 216-50-2610 56 8-14-49 Director MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits in then "naturel", or Iteme 23s or 28s-f ehow the Medical Examiner must be notified at MD Baltimore 1 XYes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4722 Pimlico Rd. 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo 1 ☐ Yes 2 X No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disable permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: if Item 27 is marked other the eny injury or other treumatic event, the 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jeremiah Flicking Mary A. Lilly ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Edmonds (Mother) 4722 Pimlico Rd. Balto.MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XSurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart 3-14-06 Dundalk, MD 21. Signature of Funeral Server Licensee 22. Name and Address of Facility Wesley Chavis, Jr. FH 2007 Eastern Ave. Balto.MD 21231 23a. Pan1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure first only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bleed Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner eb Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the e 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? luce 1 Yes 2 No 3 Probably 4 Munknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an hes autopsy performed? 1 Yes 2 MNo 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 ⊠Natural To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After it completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \(\text{Homicide} \) 1 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 MD ARCH1 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KUMAR, MD SINAL HOSPITAL OF BALTIMORE VIVER 31. Date filed (Month, Day, Year) State MAR 2 0 2006

DHMH 17 Rev 1/2001

Registrar

(1)

(Jessy

रु

Roberton

Maryland

Baltimore,

o

۵.

of Vital Records.

Division

			For State Registrar	State of Maryla		artment of H			giene 00	6 08338
	1,7		Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ath Day	3. Time of Death
	Physici /Medic		SUE C. LIST					03	Y	006 10:40 AM
	Examin		4a. Facility Name (If not institution, give		Ome.	4b. City, Town, or	Location of Death		4c. County	
-38	Liging.		GOOD SAMAR	ITAN HOS		BAL	LI MO	RE	N/	
	Funeral		5. Social Security Number 6. Sex		. last birthday) Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	h y, Year)	Birthplace (State or Foreign Country)
	Director		219-60-6224 Usual Residence of Decedent	53	713.			7/7/19	122	MARYLAND
3	ehow		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	a-f et	to	MD BALTIMO	RE	01	VERLEA				1 ☐ Yes 2 ☐XNo
4	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?
	23a	ra	600 ELMWOOD ROAD			21206			US	
-	tems tems	Funeral	The state of the s	12. Was Decedent Ever in I Armed Forces?	J.S. 13. V	Was Decedent of Hi I Yes, specify Cuba	spanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race Blac	e - American Indian, k, White, etc.
2	or I	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates:	1	1 ☐ Yes 2 🛣 No	Specify:		Specify	· WHITE
3	nour self-	edt	15. Decedent's Edu		16a, Deced	ient's Usual Occupa	ation		16b. Kind of Bu	
	n 'n	Completed	(Specify only highest grade	completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	luring most of wor)	king		,
7	giene giene er tha	mo	3		SEI	F EMPLOY	ED		RESTA	URANT
2	be lied within / 2 nouts after death with the Maryland tal Hygiene. Ital Hygiene. do other than "natural", or Items 23a or 28a-f ehow event, the Modical Evaninar must be notified at	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle,	Maiden Surnam	е)
2	Men	၉	WILLIAM FLEAGLE				EVELYN	LEASE		
_ (and saum		19a. Informant's Name/Relationship (Ty			ig Address (Street a			er, City or Town,	State, Zip Code)
2	and lealth m 27 her tr		JAMES M. LIST/HUS		Place of Dispo	ELMWOOD R	OAD BAL	TIMORE,	MD 212	
5	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tra		20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □ R	emoval from State	cemetery, cren	natory or other place	1			City or Town, State
_	rtent rtent njury		4 Donation 5 Other (Specify)			ART OF JE	1		DUNDALK	
ם ם	permit. Depart Import any inj		21. Signature of Funeral Service License	99			111			AL HOME, P.A.
			23a. Enter the disease, or compli	cations that caused the dea		5521 LOCH er the mode of dying				Approximate
(A)			shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.		25/	101			Interval Between Onset and Death
F	hysician /Medical		disease or condition resulting in death)	Due to (or as a conse		RIC	12CE	EMI	4	
E	Examiner			SMAIL	,	WEL	OBST	RUCTI	ON	
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse			012211			
(cuted nd ransil	Examine	Cause (Disease or injury that initiated events	:						
Š	ate be executed hysician and the burial-transii		resulting in death) Last	Due to (or as a conse	quence ol):					
		dical		1						
Ö :	Ine law fequires that the death certific ate has been signed by the attending p page 2 should be detached for use as	/Me	IF FEMALE:	3c. If yes, outcome of pregr	22004					
מ ב	attend for us	Physiclan/Me	in the past 12 months?	1 Live birth 2 Fel 4 Pregnant at time of	al death 3□	Ectopic pregnancy Other (specify)			23d. Date Mor	e of delivery hth Day Year
j	y the	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown	death 5	Olliel (specify)				
	ned by deta		Part II. Other significant conditions cor	ntributing to death but not re	sulting in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use contr	ibute to the cause of death?
3	n sign	d b	AORTO-SUPER	LEOR ME	SENTE	PRIC AF	2TERY	1 🗆 Y	res 2 No	3 Probably 4 □Unknown
ecords,	s bee	olete	BYPASS SU	RACRYIN	PAST	•	,	24a. Was	an 24b. V	Vere autopsy findings available prior to completion of cause of
֡֞֝֟֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֓֓֓֓֓֓֡֓֓֡֓	te ha	Completed by							rmed? 📙 d	irior to completion of cause of leath? Yes 2 No
[2]	ien: rtifica stor, p	0	25. Was case relerred to medical				26. Place of Dea	ath (Check only o		
> .	ysici nis ce direc	To B	examiner?	lospital: 1 Inpatient 2	☐ ER/Outpatien	t 3 DOA Othe	er: 4 🗆 Nursing H	lome 5 Resid	dence 6 Othe	ar (Specify)
O 7	ng Pr		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe h	now injury occurr	ed
io lioisivi	eath. or: A the fu	catl	2 Accident investigation 3 Suicide 6 Could not be				res 2 □No			
<u> </u>	or Ar fiter d Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stri cify)	eet, lactory, office		28f. Location (S City or Tow		er or Rural Route Number,
	prital ours a eral [29a. Certifier 1 Certifying Phys	sician: To the best of my kr	coulodge death	a coursed at the time	and class	and due to the		man as stated
:	To the hospital of Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical	(Check only 2 Medical Examination)	ner: On the basis of examinand manner stated.	nation and/or inv	vestigation, in my of	pinion, death occu	rred at the time,	date and place, a	and due to the cause(s)
:	vithin o th	Me	29b. Signature and title ol certifier			29c. License			29d. Date signed	(Month, Day, Year)
•	/		> K. Slibett	in MD		RES	000		03/17	2006.
*	6		30. Name and address of person who co	mpleted cause ol death (Ite	em 23a) (Type,			[MN 21229
_	り		30. Name and address of person who co SRICATHA KANUK	MURU, 5601	LOCH	KHICH	BCVD,	Brick	(1 (OKC)	11115-21231
	Sta	16.0	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	4,				
	Registr	rar	MAR 2 0 2006	Aleghan So	1000	3				

	deline L: -01903	Lgh	tsey Unpend item# 23a,	se Typ PII,27	e or Pri	int in E perME.C	Black In 854,4/1	delib 3/06	ole Ink.	Ensure A	All Copie	s Are	e Leg	ible.		
crr	ו		1 - For State Registrer	'St	tate of N	larylan			ent of H ate of L		Mental H	ygier Reg. N		6 (183	39
			1. Decedent's Name (First, Middle					177700	210 0, 1	304111	2. Date of D	eath		Von	3. Time of	f Death
	Physic /Medi		Madeline Kim								March)ay	2006	7:29	РМ
	Exami	ner	4a. Fecility Name (If not institution Johns Hop	-				4b. Ci	ity, Town, or Balti	Location of Deat	th	4		y of Death		
5	Funeral		5. Social Security Number	6. Sex	7. A		last birthday)		der 1 Year	If Under 24 Hrs		irth		9. Birthol	ace (State o	or Foreign
	Director		220-78-3507	1 🗆 M	2 ∏ F	47	Yrs.	Month	ns Days	Hours Min.	2-26	- 59		MD'	ary)	
	land ow		Usual Residence of Decedent 10a. State 10b. County			10c. Cit	y, Town or Lo							10	d. Inside Ci	ity Limits
_	13-UU30 72 hours after death with the Maryland 72 hours after death with the Maryland 7 naturel; or flems 23a or 28a-f show coloni Examinar must be motified at	ctor	MD				Balt	imc	ore						1 📉 Yes	2 No
0	with the	Funeral Director	10e. Street and Number 1005 McAleer	G				10f.	Zip Code	21202				What Count	try?	
1	leath v	erai	11. Marital Status		Nas Deceden	t Ever in U	.S. 13. 1	Was De	cedent of Hi	21202	Specify Yes or N		. S . A	ce - America	an Indian.	
u	<u> </u>	Fun	1 ☐ Never Married 2 ☐ Marri	ed 1	Armed Forces I □ Yes 2 ∑ If Yes, Give	?			specify Cuba s 2 XIX io	spanic Origin? (S n, Mexican, Puer Specify:	to Rican, etc.)			ick, White, e		
٤	2-UUSO 72 hours after haturel; or its	d by	3 ☐ Widowed 4 ☐ Divorced		Year or Dates	:						4.01				
u Z	27 nin 72	piete	15. Decedent (Specify only highes Elementary/Secondary (0-12)	t grade coi	mpleted)	(F.)	(Give	kind of DO NOT	Isual Occupa work done of Tuse retired	ation furing most of wo)	rking	160.	Kind of E	Business/Ind	ustry	
5	giene giene tha	Completed	9th		College (1-4or	5+)	Hom	ema	ker				lome			
7	be file	Be	17. Father's Name (First, Middle, Walter Reddic							18. Mother's Na		e, Maide	an Suma.	me)		
Ì	Bailtimore, Maryland Z IZ 13-0030 permit. Pages 1 and 2 should be filed within 72 hours af Department of Heelth and Mental Hygiene. Importent: if item 27 is marked other than "naturel", or any Injury or other traumatic event, the Medical Examples.	၉	19a. Informant's Name/Relationsl		Print)		19b. Mailir	ng Addre	ess (Street a	Mary Number or Re		ber, City	or Town	, State, Zip	Code)	
Ě	and 2: elth ar		Kenyaha Jones	5			109	s.	Monr	oe St.	Balto.	MD.	212	23		
3	or of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Remo	oval from State	20b. F	Place of Dispo	sition (f	Name of or other place	θ)	Date 24-06			- City or To	wn, State	
1	it. Pa		4 Donation 5 Other (State 21. Signature of Funeral Service)		01	, 30	créd			ss of Facility W ∈				k,MD	ער	
á	Depart Perm		Melento	1	Tha.	-	2	007	Eas	tern Av	re. Bal	lto.	MD,	21231	1	
			23a. Parti. Enter the disease, of shock, or heart failure. Ust	complication	ons that cause ause on each	ed the deat	h. Do not ent	er the m	node of dying	g, such as cardia	c or respiratory	arrest,			Approximat Interval Bet	tween
	Priysician		Immediate Cause (Final disease or condition resulting in death)		lethadon										Onset and I	Death
	/Medical Examiner			(Due to (or a	s a conseq	uence of):		a							
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. —	Due to (or a	s a cursed	dence of).									
	executed n and al-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or a											
c c		_	Tooding in dodin, Edot		Due to (or a	s a conseq	uence or):									
00	DB/ tiflicate g phys	edic		d												
3	S, P.O. BOX 08/000 es that the death certificate be e igned by the attending physicier be detached for use as the buri	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		f yes, outcom 1□Live birth			Ectopic	c pregnancy					ate of deliver	•	Year
	at the dead by the all letached for	ysici	1 ☐ Yes 2 ☐ No 9√2 Unknown		4□Pregnant 9□Unknown	at time of d	leath 5	Other	(specify)				141	Ona i	Day	i oa:
	that the hold by a detact	by Ph	Part II. Other significant condition	ns contribu	uting to death	but not res	ulting in the u	nderlyin	g cause give	en in Part I.	23e. Did	tobacc	use con	tribute to the	e cause of c	death?
3	COTOS, w requires been sign should be		Hypertensive athero	sclero	otic car	diovaso	ular di	sease	e; obes	ity;	1 🗆] Yes	2 No	3 Proba	ably 4 🗀	Jnknown
		Completed	diabetes mellitus;	asthr	na							opsy	24b.	Were autop	sy findings	available ause of
-	The The icate?										1 X Yes	-	40	death?	2□ No	
,	ysiciai s certii directo	o Be	25. Was case referred to medical examiner? 1 ▼ Yes 2 □ No	Hosp	ital: 1 ☐ Inpat	tient 2°□	ER/Outpatier	nt 3112	DOA Othe	26. Place of De ar: 4 ☐ Nursing I	ath <i>Check only</i> Home 5 ☐ Rea		6 □Ot	her (Specify)	
	n OT ng Phy tter thi neral	ı.	27. Manner of Death 1 □Natural 5 □ Pendin	2	8a. Date of In (Month, D		28b. Time of		28c. Injury Work		28d. Describe				/	
me	DIVISION or Attending after death. Director: After	Certification:	2 ☐ Accident investig	not be	1d 3/17/2	2006	Fnd 6:5		10,		unk	/Ctro -4		h	D- 1- 1/	
C d	after a Direct of In Dy	ertif	4 Homicide determ	_	8e. Place of In building, (Found at	etc. (Specif		eet, tact	tory, office		28f. Location City or To Baltimor	own, Sta	ite) 100	ber or Rural 05 Mcale	eer Ct.	loer,
16k pand	To the Hospital or Attending Physician: The law within 24 hours after death. (To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifyin (Check only 2 XMedical	g Physicia	n: To the bes	at of my kno	wledge, deati	h occurr	ed at the time	ne, date and place	e, and due to the	e cause	(s) and m	anner as sta	ated.	
10	the Hin 24 the Fi	Medical	one)	A	and manner s	of examina stated.	ition and/or in			oinion, death occi	urred at the time					i)
	Twiti Or	-	29b. Signature and little of certified		1			1	29c. License		. ·			ed (Month, E		
	07		30. Name and address of person	who comple	eted cause of	death (Iter	n 23a) (Type,	Print)		0.C.M.I	L.	mar	CH L	8, 200	70	
	d		May a.		ole, n	S	111		n Stre	et, Balt	imore,	Mar	y1an	d 2120)1	
	St Regist	ate rar	31. Date filed (Month, Daly, Year) MAR 2 0	2006	32 legis	trar's Signa	ture /	3ch								

			1 - For State Registrar	State of N	Maryland /	,	artment o			and Mo		giene	06	08340
	Physici	an	Decedent's Name (First, Middle				-				2. Date of Dea Month MArch		Year_	3. Time of Death
40	/Medic	al		R. Lein			45 O' T			(5)	MArch			
200	Examin	er	4a. Facility Name (If not institution 17 Strawberrs	_	ər)		4b. City, To		e Ri					
4.	Funeral	4,	5. Social Security Number	6. Sex 7. /	Age (In yrs. last	birthday)	If Under 1	Year	If Under	24 Hrs.	8. Date of Birth	1		
8	Director		215-54-1002	1□ M 2√ F	56	Yrs.	Months [Days	Hours	Min.	(Month, Day Dec. 1	4,19	49 Mar	yland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation					•		
	Maryl -f ehc	tor	Md Harf	ord	Jo	ppa							1	1 ☐ Yes 2 🔼 No
	be fled within 72 hours after death with the Marylar Hygiene. d other than "naturel", or flems 23e or 28s-f ehow event, tra Medical Exaction trival for rotified at	Director	10e. Street and Number				10f. Zip Ci	ode				10g. Citize	n of What Cou	untry?
	23 c	aiD	2902 Trout T	errace			21(085				USA		
	er des	Funerai	11. Marital Status	12. Was Deceder Armed Force	s?	13.	Was Deceder If Yes, specify	nt of His y Cuban	spanic Orig	gin? (Spec n, Puerto F	cify Yes or No- Rican, etc.)	14		
36	rs aft	by F	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☑ Divorced	If Yes Give			1 ☐ Yes 21	⊘ No	Specify:			S	pecify: W	hite
Š	2 hou	ted	15. Decedent	t's Education		6a. Dece	dent's Usual (Occupat	tion			16b. Kind		
212	ithin 7 19.	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4c			dent's Usual (kind of work DO NOT use maker		uring most	t or workin		otan '	homo	
2	iled w tygier her th		12th 17. Father's Name (First, Middle,	/ agt)		101116	maker		10 Matha	ria Blama				
and		Be C	William C.	•							Penta	Maluell St	umame)	
<u></u>	\$ 5 E E	10	19a. Informant's Name/Relations		1	9b. Mailir	ng Address (S	Street ar				r, City or 1	Town, State, Z	lip Code)
Ž	1 end 2 Health a tem 27 ls		Keith Lein	/ son		2902	Trou	ıt 7	Terr.	ace	Joppa	MD	21085	
Baltimore,	of Hea of Hea If Item or oths		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from Sta	te ceme	etery, crei	sition (Name natory or othe	er place			ate		-	
Ē	L. Pages trient of tent: If It		4 ☐ Donation 5 ☐ Other (S	pecify)	Garde		of Fa		1	3/18	,			
Ba	permit. Pages Department of Important: If I any injury or o		21. Signature of Funeral Service	Licensee	01.	C	Name and in one l	Address	s of Facility Fune	y 30	00 Mac	e Ay	e.Bal	to.MD
			23a. Part1. Enter the disease eshock, or heart failure. List	complications that caus	sed the death. D	_					respiratory an		BBCX	Approximate
	Physician		Immediate Cause (Final				CEI	^						Onset and Death
	/Medical		disease or condition resulting in death)	d	as a consequence		,							8 Manu
*	Examiner		Sequentially list conditions.	b	as a consequence									
	p iš	inei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
	xecut and al-tran	Examiner	that initiated events resulting in death) Last	C. Due to (or a	as a consequenc	ce of):								
8760	The law requires thet the death certificate be executed the has been signed by the ettending physicien and age 2 should be detached for use as the burial-transit	dicai E		L _d										
68	ntificat ng phy as th	Aedi	ACCENALE.											
Вох	eath certific ettending p for use as	lan/I	1F FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal dea	ath 3[Ectopic preg	gnancy				23		*
0	the dec	Physiclan/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant 9□Unknown	t at time of death 1	5 [Other (spec	cify)					WOITH	Day (Gai
О.	res thet the de signed by the e i be detached f	/ Ph	Part II. Other significant condition	ons contributing to death	n but not resulting	g in the u	nderlying cau	ise giver	n in Part I.		23e. Did to	bacco use	contribute to	the cause of death?
rds	quires n sign	ed by									1 🗆 Y	es 2 🗆	No 3□Pro	obably 4 Bunknown
000	aw require is been sig 2 should b	Completed									24a. Was	an	24b. Were au	topsy findings available
ž		mo:									autop perfor	med?	death?	
Division of Vital Records,	Attending Physicien: The Ir death. ector: After this certificate haby the funeral director, page	Be (25. Was case referred to medical examiner?								(Check only or			are it on to
<u></u>	Physic this crail dire	. To	1 Yes 2 No 27. Manyler of Death	Hospital: 1 Inpa		Outpatier	nt 3 DOA	Other	r: 4 □ Nu					House
o	ding th. : After fune	Certification:	1 ☑Natural 5 ☐ Pendin 2 ☐ Accident investig	g (Month, L	Day Year)	Injury	м 200	C. Injury Work? 1 ☐ Y	ai ′es 2 □ i		ou. Describe ii	ow injury t	occurred	
Visi	or Atten after deat Director: in by the	Ifica	3 Suicide 6 Could in determining	not be 28e. Place of	Injury - At home,	, farm, str	eet, factory, c	office		2	8f. Location (S	treet and	3. Time of Death 4, 2006 9:15a 3. Time of Death 9:15a 3. Time of Death 9:15a 4, 2006 9:15a 4, 2006 9:15a Maryland 10d. Inside City Limits 1 Yes 2 No 2 No 14. Race - American Indian, Black, White, etc. Specify: White Kind of Business/Industry 1 home 10 21085 Location - City or Town, State SSVIlle MD Ave.Balto.MD Essex 21221 Approximate Interval Between Onset and Death Onset and Death Ouse contribute to the cause of death? 2 No 3 Probably 4 Juminown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 No No No 1 No No No	
	ital or A rs after el Dire led in by	Cert	building, etc. (Specify) City or Town, State)											
	To the Hospital or At within 24 hours after of To the Funerel Directompletely filled in by	edicai	29a. Certifier 1 Certifyin (Check only 2 Medical	Examiner: On the basis	s of examination	dge, deat and/or in	h occurred at vestigation, in	the time	e, date and inion, deat	d place, a th occurre	nd due to the old at the time, o	ause(s) ai	nd manner as lace, and due	stated. to the cause(s)
	To the Ho within 24 i To the Fu completely	Med	29b. Signature and title of certifie	and manner	stated.				number					
1	1 5 5		> A X10°	E He	1100	R	300		5 10	2			1	
η)		30. Name and address of person	who completed cause o	of death (Item 23	a) (Type,	Print)		<u> </u>	Λ,	, <u> </u>			16 WD 513
			4+KOZE	Mane	6/2 0	101	C .	1-0	KI	141	IE K	2176	1111/	111) 214
-	Sta	ite	31. Date filed (Month, Day, Year)		istrar's Signature	1								

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. R

2006

		1	For State Registrar	State of Maryl		artment of H			iene	08342
l _y	DI.	- 0	1. Decedent's Name (First, Middle, Last)	Mrs	4			2. Date of Deat	h Day Year	3. Time of Death
£	Physicia /Medic	al	JAMES LEON		ER	4h Ch. Tour	Location of Death	MAR	16 200 6 4c. County of Deat	
	Examin	er '	4a. Facility Name (If not institution, give s		>		TIMORE		N/A	
	Funeral Director		5. Social Security Number 6. Sex		yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, 4/2/19	Year) 9. Birt Co WES	hplace (State or Foreign nuntry) VIRGINIA
	death with the Maryland ime 23a or 28a-f show If TIME Le nutilled at		Usual Residence of Decedent 10a. State 10b. County		. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ XNo
	he Ma	Funeral Director	MD BALTIMO	JKE	PARKVI	10f. Zip Code		1	0g. Citizen of What Co	
	with t	ļ	1225 DEANWOOD ROAL)		21234			USA	,
	death me 2;	nera		12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H	ispanic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
	72 hours after natural, or ite	þ	1 ☐ Never Married 2 【 Married 3 ☐ Widowed 4 ☐ Divorced	1 (XYes 2 □ No If Yes, Give Year or Dates: VI		1 ☐ Yes 2 ☐XNo	Specify:		Specify	ITE
121	within	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+) YFARS	(Give	dent's Usual Occup e kind of work done o DO NOT use retired RVISOR	during most of wor	king	16b. Kind of Business HIGHWAY ADMINIST	•
	other other	Be Co	17. Father's Name (First, Middle, Last)	ILARS			18. Mother's Nar	ne (First, Middle, I		
/lan	2 should be and Mental le marked of aumatic eve	To B	ROBERT MERCER					CATHERIN		
-			19a. Informant's Name/Relationship (Ty BARBARA ANN MERCE)			ing Address (Street DEANWOOD		iral Route Numbei ALTIMORE	, City or Town, State, . MD 21234	
-	Pages 1 and nent of Health int: If item 27 iry or other ti		20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □ P	lemoval from State	ob. Place of Disposemetery, cre	osition (Name of imatory or other place	ce)	Date	20c. Location - City or	
Baltimore	permit. Pages Department of I Important: If its eny injury or of once.		4 Donation 5 Other (Specify) 21. Signature 1 Funeral Service Licens		2		ss of Facility TH	E JOHNSO	BALTIMORE, N FUNERAL 1	HOME, P.A.
	% O E = 0		233 Port Enter the disease or compl	ications that caused the		521 LOCH				286 Approximate
E.	5. 4		23a. Part1. Enter the disease, or complehock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	C	-1.1	~ 47	,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a co	nsequence of):	ephalo	painy			1 week
	Examiner	<u>.</u> .	Sequentially list conditions.	Due to (or as a co	accompany of):					
A	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence or).					
,	te be executed ysicien and e burial-transit		that initiated events resulting in death) Last	Due to (or as a co	nsequence of):					
8760	physici physici s the bu	dicai		d						
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of printing the first section in the section of the section in the section	Fetal death 3	□Ectopic pregnancy □ Other (specify) _	у		23d. Date of de Month	livery Day Year
ds, P.	uires that I signed by ifd be deta	þ	Part II. Other significant conditions co		ot resulting in the	underlying cause giv	ven in Part I.	23e. Did to	bacco use contribute t es 2	o the cause of death?
Records,	fhe law requir te has been si age 2 should l	Completed						24a. Was autop perfor	sy prior to med2 death?	utopsy findings available completion of cause of
Vital	ysiclan: The is certificate hidirector, page	Be C	25. Was case referred to medical examiner?					ath Check only o	ne)	
of <	Physiclan: r this certifica ral director, p	2	1 ☐ Yes 2 🐪 No 27. Manner of Death		2 ER/Outpatie	SIL 3 DOA		,	ence 6 Other (Spe	ecify)
	ding After fune	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye		Wo	rk?]Yes 2□No	250. 5555125	on injury coodings	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S		street, factory, office		28f. Location (S City or Tox	street and Number or F n, State)	dural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical C	29a. Certifier (Check only one) Certifying Phy 2 Medical Exam	rsician: To the best of m iner: On the basis of exa and granner stated	y knowledge, dea amination and/or i	ath occurred at the transfer in my o	me, date and plac opinion, death occ	e, and due to the ourred at the time,	cause(s) and manner a date and place, and du	is stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier		47	29c. Licen:			29d. Date signed (Mor	
			beffer 7 = 3	ting 1	70	D 00	5372	. 2	MAR 10 AN HOS	6 2006
			A //	ompleted cause of death	(Marie 00-) (Tree					
	12+1		go. right gard and an area	PILCIN 32. Registrar's	4 MI	Print)	600D S	MARIT	AN HOS	P

DAVON McDOWNEY 06-01245 State of Maryland / Department of Health and Mental Hygiene For State Registrar 1. Decedent's Name (First, Middle, Last) **Physician** Q. Devon McDowney /Medical Examiner 19213 AQUSCO ROAD Social Security Number **Funeral** 228-65-3163 1√M 2□F Director Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10a. State 10b. County r then "natural", or items 23s or 28s-f show the Medical Examinar must be notified at by Funeral Director MD 10e. Street and Number 19213 Aquasco Road 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) 7th permit. Pages 1 and 2 should be filed w Department of Heelth and Mental Hygier Important: If Item 27 I e marked other it any Injury or other traumatic event, ILIS 900.8. 17. Father's Name (First, Middle, Last) Be Erwin Williams 19a. Informant's Name/Relationship (Type, Print) Constella Bailey (Aunt) 20a. Method of Disposition 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Examine

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death 2. Date of Death 3. Time of Death Month Day Year FEBRUARY 18, 2006 10:25A. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death PRINCE GEORGES BADEN If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 10,1992 Birthplace (State or Foreign Country) 13 Yrs Richmond, 10c. City, Town or Location 10d. Inside City Limits Yes 2□No Prince Georges Brandywine 10f. Zip Code 10g. Citizen of What Country? 20613 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐ Yes 2 ☐ No Yes, Give X 1 ☐ Yes 2 No Black Specify: Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Unemployed Unemployed 18. Mother's Name (First, Middle, Maiden Sumame) Aretha McDowney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 671 Macedonia Lane Colonial Beach, Va 22443 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State IX Burial 2 ☐ Cremation 3 ☐ Removal from State Macedonia Bapt. Cem. 2/23/06 Colonial Beach, VA ²² Name and Address of Facility Austin Royster Funeral Home 3821 14th Street NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death INTRAORAL GUNSHOT WOUND Due to (or as a consequence of) Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 △Yes 2 □ No 15 Yes 2 🗌 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 \square Nursing Home 5 \square Residence 6 \bigcirc Other (Specify) SCENE Hospital: 1 M Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of

or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit the attending physician and Division of Vital Records, P.O. Box 68760, been signed by the should be detached page 2 hes this certificate death efter death within 24 hours eff To the Funerel D completely filled in the

Physician/Medical

Completed by

Be

2

Certification:

Medical

1 Natural 2 Accident

3 Suicide

29a, Certifier

4 Homicide

5 Pending investigation 2 6 ☐ Could not be determined

/18/06

RESIDENZE

FOUNDY 10:18AM 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 2 No

28d. Describe how injury occurred SUBTECT SHOT SELP

 Location (Street and Number or Rural Route Number, City or Town, State) 19213 ARVASCO RD, BADEN MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number O.C.M.E.

29d Date signed (Month Day Year) FEBRUARY 19, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANA RUB10

111 PENN STREET BALTIMORE, MARYLAND 21201

State Registrar

MAR 2 0 2006

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens

		For State Registrar	State of Ma	-	epartm Certific			мептат ну	giene Reg. No.	006	08344	
Physicia	ın	1. Decedent's Name (First, Middle, Las Morton		LAel	_			2. Date of De Month	Day		3. Time of Death 2210 N	л
/Medic Examin		4a. Facility Name (If not institution, give	street and number)	HAEL	4b.	-	or Location of Deat		7	County of Dea		_
		John Anund 5. Social Security Number 6. S		(In yrs. last birt	hday) If U	nder 1 Year	If Under 24 Hrs		rth	H H	thplace (State or Foreir	
Funeral Director		148-26-2236	M 2□F		rs. Mon	iths Days	Hours Min.	July 1	ay, Year)	929 Ok	thplace (State or Foreig ountry) Lahoma	<u> </u>
/land	1	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits	s
e Man	ctor	Maryland Howard	I	Ellicot							1 ☐ Yes 🏋 🗙 No	0
death with the Maryland ome 23a or 28a-f ehow Ir mast be notified	Directo	10e. Street and Number 2500 Kensington G	ardens #400	5	101	f. Zip Code 21043			_	sen of What Co	ountry?	
ter death	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		13. Was D		Hispanic Origin? (S an, Mexican, Puer	Specify Yes or Note to Rican, etc.)		14. Race - Ame Black, Whit		
UU36 hours atter ural', or ite	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □Yes 2 🔯 No If Yes, Give Year or Dates:)		es 2√2 No	Specify:			Specify:	White	
	Completed	15. Decedent's Ec (Specify only highest gra	lucation de completed)	16a.	Decedent's (Give kind o	f work done	during most of wo	rking	16b. Kir	nd of Business		
the one	omp	Elementary/Secondary (0-12)	College (1-4or 5+		wner	OT use retire	d)		Aut	o Salva	age Center	
d be filed ontal Hygic wed other c event, II	Be C	17. Father's Name (First, Middle, Last)	•				18. Mother's Na	me (First, Middle				
Z 3 2 5 6 1	2	William Henry Gra			Mailing Ada	trans (Strant		horlacks		Tour State	Zip Code) 21043	
Z ar		Opal Michaels- wi					n Garden:					
ges 1 and of Heelt It is m 2 or other	1	20a. Method of Disposition 15☐ Burial 2 ☐ Cremation 3 ☐	- 	20b. Place of		(Name of		Date		cation - City or		
Little Paragraph		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funer I) ervice Licen	v)	Meadowri			Park 3/16	/2006	Elkr	idge, M	10	_
Balti permit. I Departm Importa any inju		Magn	1300		Gary 7250	L. K	aufman Fi ington B	uneral H lvd. El	Iome (at MMP,	INC. 21075	
		23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused to one cause on each line).	ot enter the	mode of dyi	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death	
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. It te			10/0	teart	1210	EAC	ه احد	Onsol and osalin	_
Examiner		Sequentially list conditions	b	consequence	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							
led nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence o	or):							
68 / 60, ificate be executed g physicien and as the burial-transit	Exar	that initiated events resulting in death) Last	C. Due to (or as a	consequence o	of):							
68 / 6U	edical		d									_
E Oras	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o		۰۵۲۰۰۰				2	23d. Date of de	livery	
ecords, P.O. BOX iaw requires that the death cert as been signed by the ettendin 2 should be detached for use	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 2 4□Pregnant at ti 9□Unknown			oic pregnanc or (specify) _	у			Month	Day Year	
dS, P.C	y Ph	Part II. Other significant conditions of	ontributing to death but	not resulting in	the underly	ing cause gr	ven in Part I.	23e. Did	tobacco u	se contribute to	o the cause of death?	
VI(al HECONGS, sicien: The law requires t certificate has been signe rector, page 2 should be o	ted by							10	Yes 2	□No 3□P	robably 4 hriknow	n
The law recate has be page 2 shi	Completed							24a. Was		24b. Were as prior to death?	utopsy findings available completion of cause of	Θ
Vital H	e Co	25. Was case referred to medical					26 Place of De	1 ☐ Yes ath (Check only	2 X No	1 Yes	s 2ltmo	
Of VITA Physician: ribis certific ral director,	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatien	t 2 KER/Out	tpatient 3	DOA Ot	200	Home 5 Res		3 ☐Other (Spe	əcify)	_
On O		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. T	ime of njury M	28c. Inju Wo	ryat rk?]Yes 2 ☐ No	28d. Describe	how injury	y occurred		
St. deat deat the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	e 28e. Place of Injur	y - At home, fai			1165 20140		Street and		lural Route Number,	
DIV To the Hospital or A within 24 hours effer To the Funerel Direc completely filled in by			building, etc.									
To the Hospital within 24 hours of To the Funerel I completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of niner: On the basis of a and manner state	examination and	, death occu d/or investig	irred at the ti ation, in my	me, date and place opinion, death occ	e, and due to the urred at the time	cause(s) date and	and manner as place, and due	s stated. e to the cause(s)	
To the within 2 To the complete	Me	29b. Signature and title of certifier	10 1	Depu	ty	29c. Licen				e signed (Mont	th, Day, Year)	
,		Millen		mo	T D-1-0	De	nerick		_3	111/4		
20		30. Name and address of person who	Jones,		Type, Print)	An	nerica	2 20	03	5		
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar		1 4							
DHMH 17 Rev 1/20		MAR 2 0 200	06 Kenn	J. A	TOR WELL							

			For State Registrar	State of Maryl		artment of H			iene g. No.	06	08345
	Physici	an	1. Decedent's Name (First, Middle, Last)	MCCA	FFRey	/	2. Date of Death Month	Day	Year 2006	3. Time of Death 2:47 P M
	/Medio	er	4a. Facility Name (If not institution, give	7 medical C	enter		imore)	4c. Cour	nty of Death	
	Funeral Director		417 30 3132	7. Age (In) M 2□F 74	vrs. last birthday) Yrs.	tf Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day JAN 1	1932	9. Birthpi Coun	lace (State or Foreign try)
	the Maryland 28s-f show	Jo.	Usual Residence of Decedent 10a. State 10b. County MD N/A		City, Town or Lo					10	0d. Inside City Limits
	death with the Maryland ms 23a or 28s-f show rmust Le notified at	Direct	10e. Street and Number			10f. Zip Code	04	10	Og. Citizen	of What Coun	try?
	or Ite	by Funeral Director	524 N. Charles 11. Marital Status 1 Never Married 2 Married 3 Widowed	Street, A 12. Was Decedent Ever in Armed Forces? 1 Ses 2 No lif Yes, Give Year or Dates: Ko	n U.S. 13. \	3 212 Was Decedent of Hi f Yes, specify Cubar 1□ Yes 2★No		pecify Yes or No- o Rican, etc.)		USA lace - Americ lack, White, o	
Ŕ	n 72	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation	16a. Deced (Give life. I	dent's Usual Occupa kind of work done d DO NOT use retired,	urina most of wor	king	16b. Kind of	Business/Ind	lustry
P	s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other than other treumatic event, that Mi	To Be C	17. Father's Name (First, Middle, Last) Raymond McCa	ffrey	,		18. Mother's Nan unk	ne (First, Middle, M	faiden Sum	ame)	
	12 g		19a. Informant's Name/Relationship (7) Kevin McCaffre	, , ,		ng Address (Street a Delancey					Code) IY 10002
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	•	ake Crem	atory	/2006 E	Beltsv	ille,	
Ball	Departi Departi Imports eny inj		21. Signature of Funeral Service Licens		986 8	Name and Address FA, Stepl 17'Green	nen D. L. Pasture	ôhrmann, s Drive;	PA Towso	n, MD	21286
	Physician /Medical Examiner		23a. Pant1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	nonia	er the mode of dying	g, such as cardiad	or respiratory arre	est,		Approximate Interval Between Onset and Death
8760,	certificate be executed adding physicien and use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Embi Unidentying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con Due to (or as a con Due to (or as a con							
Ä.	e death the atter ted for u	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ I 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)				Date of delive Month	ry Day Year
rds, P.	law requires that the as been signed by th 2 should be detache	Ď	Part II. Other significent conditions co	entributing to death but not	resulting in the u	nderlying cause give	on in Part I.		es 2 No		e cause of death? ably 4 🗗 Unknown
Ř	The ate h	Completed						24a. Was ar autops perform 1 Yes 2	y ned?	prior to cor death?	psy findings available inpletion of cause of
Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ② No	Hospital:	2 ☐ ER/Outpatien	it 3 DOA Othe		ath <i>(Check only one</i> Iome 5 ☐ Reside		Other /Snecifi	()
	on Affer	atlon: T	27. Manner of Death 1 M Naturat 5 Pending investigation	28a. Date of Injury (Month, Day Yea	28b. Time of	28c. tnjury Work		28d. Describe ho			,
=	± ± ± =	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of tnjury - / building, etc. (Sp	At home, farm, str pecify)	eet, factory, office		28f. Location (Sti City or Town		mber or Rura	l Route Number,
	To the Hospital within 24 hours a To the Funerel C completely filled	edical	29a. Certifier 1 Certifying Phy check only one) 2 Medical Exam	/sicien: To the best of my iner: On the basis of exar and manner stated.	knowledge, death nination and/or in	n occurred at the tim vestigation, in my op	e, date and place pinion, death occu	, and due to the ca irred at the time, da	ause(s) and ate and plac	manner as st e, and due to	ated. the cause(s)
	To the I within 2. To the I complet	M	29b. Signature and title of certifier	to mix		29c. License	9719	29	21	ned (Month,	Day, Year)
	-1		30. Name and address of person who come for the form	completed cause of death	(Item 23a) (Type,	Greene	Street.	Beltimor	e, ſ	ND	21201
	Sta Registi		31. Date filed (Month, Day, Year) MAR 1 8 20	Registrar's S	ignature	W.		-			

MCCAFFRY, PAKIX 32

			For State Registrar	State of Maryland / Depa	artment of Health and Mortificate of Death	ental Hygien	UUU	08346		
	Physicia	an-	1. Decedent's Name (First, Middle, Last)	JEAN		2. Date of Death Month Da		3. Time of Death		
	/Medic Examin		4a, Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of Death	40	c. County of Deat	1		
	Funeral		5. Social Security Number 6. Sex		If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day, Year	Altim 9. Birtl	of E		
	Director		247-86 1774 1 Usual Residence of Decedent	M 2 F 5 9 Yrs.	Months Days Flours Will.	5 29 1	747	"3, C,		
	show ed at	or	10a. State 10b. County	10c. City, Town or Lo	•			10d. Inside City Limits 1 Yes 2 No		
	or 28a-f	Olrect	10e. Street and Number	n. Aft -	i Mo RiE 10f. Zip Code	10g. C	itizen of What Co	untry?		
	death w	Funeral Director	5020 God 1	12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - Ame			
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. And the strain of the them "hat the Maryland Examiner must be notified at any injury or other traumatic event, the Maryland Examiner must be notified at once.	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □Yes 2 MNo	1 ☐ Yes 2 No Specify:	sican, etc.)	Specify: B	IACK		
15-0036	in 72 hou	Completed	15. Decedent's Edu (Specify only highest grade	completed) (Give	dent's Usual Occupation a kind of work done during most of workin DO NOT use retired)	og .	Kind of Business/	Industry		
212	filed withit Hygiene.		Elementary/Secondary (0-12)	College (1-4or 5+) H 0 L	ISE HEFFER	(First, Middle, Maide	40 + E/			
Maryland	2 should be fill and Mental H is marked off	To Be	17. Father's Name (First, Middle, Last) CUR+15 LEE	HIC HMAN	TNE		n Sumame)	GORE		
Mary	and 2 sho ealth and N n 27 is ma er trauma		19a. Informant's Name/Relationship (Ty	po, Print) DAV 64 LFR 19b. Maili MING 502	ing Address (Street and Number or Rura	the same of the sa	or Town, State, 2 BAH Mo			
ore,	Pages 1 and 2 nent of Health out: if item 27 ary or other tra		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	20b. Place of Disponentary cre	osition (Name of Dimetory or other place)	ate 20c. 1	Location - City or	Town, State		
Baltimore,	permit. Pages Department of Importent: If it any injury or once.		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	GI(17.2.1V)	2. Name and Address of Facility 2, 4	31 E. O.	WERS+	2/1/2		
m I	825 5 8		23a. Part1. Enter the disease, or compl	cations that caused the death. Do not en	MILL H WEATHER	FORD 4/5	BAIton	Approximate		
}	Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each line.	LIN Inforction		-	Interval Between Onset and Death		
4	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	Heprt Paris	10		untous '		
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
8760,	cate be executed physician and the burial-transit	I Exa	that initiated events resulting in death) Last	Due to (or as a consequence of):						
9	tificate I	Aedical	IE EENALE.	1.						
Вох	that the death certifii ed by the attending t detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of dea Month	ivery Day Year		
P. O.	hat the o	Phys	9 □ Unknown	9□ Unknown	undertying cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?		
ords,	w requires that been signed b should be deta	ted by	Demart	in		1 🗆 Yes	2 1 100 3 Pr	obably 4 Unknown		
Vital Records,	e la has	Completed	H-19-a	ten scory		24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of 2 No		
/ital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	26. Place of Death					
	S D	n; To	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time (Injury)		ne 5 Residence 28d. Describe how inj		cify)		
Division of	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, s	M 1 ☐ Yes 2 ☐ No	28f. Location (Street		ural Route Number,		
Ö	urs after eral Dire		4 Homicide	building, etc. (Specify)	the appropriate the time date and place	City or Town, Sta		estated		
	To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in I	edical		sicien: To the best of my knowledge, dea ner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurr	ed at the time, date a	nd place, and due	to the cause(s)		
ì	To the within 2 To the complet	Σ	29b. Signature and title of certifier		29c. License number		Date signed (Mont			
4				ompleted cause of death (Item 23a) (Type	Print) Tous ou pro	2128	L Dr	Wiley		
	Sta Regista		31. Date filed (Month, Day, Year) MAR 2 0 2006	32. Registrar's Signature	rath)					

DHMH 17 Rev 1/2001

ORIGINAL

	1 - For State Registrar	State of	•	epartment (Certificate	of Health and M of Death		eg. No.	106	0831
	Decedent's Name (First, Middle	, Last)				2. Date of Dea			3. Time of
ician	Arnett	F	rancis		Polk	Month O3	Day 1 4	2006	9:30p
dical	4a. Facility Name (If not institution			4h City To	wn, or Location of Death	03		county of Deat	
niner								Baltim	
	Manor Care No	ursing HC	ome Age (In yrs. last birth		OWSON Year If Under 24 Hrs.	8. Date of Birth			
al		1⊠M 2□F	67 Y	Months D	ays Hours Min.	(Month, Day	, Year)		hplace (State or
or	212-36-3395 Usual Residence of Decedent		07			11 2	4 5	38]	MD
	10a. State 10b. County		10c. City, Town	or Location					10d. Inside Cit
ក	MD	7)	Balti	mara					X Yes
Director	MD N.	A	Daiti	10f. Zip Co	ode.		On Citize	en of What Co	untry?
급	Toe. Street and Number			101. 210 00	, , ,		og. On.	J. O. W. 141	uy.
Funerai	4409 Kathland	d Ave	ant Francis III S		21207	ocifu Vos or No	14	U.S.A 1. Race - Ame	
- E		Armed Force	es?	If Yes, specify	t of Hispanic Origin? (Sp Cuban, Mexican, Puerto	Rican, etc.)	,	Black, White	
by F	1 Never Married 2 Marri	fYes, Give		1 □ Yes ½ 5	No Specify:		9	Specify: D	Black
d b	3 Widowed 4 Noivorced	Year or Date					101 10		
Completed	15. Decedent (Specify only highest	's Education it grade completed)	16a. L	Decedent's Usual (Give kind of work (occupation done during most of work retired)	ing	16b. Kind	d of Business/	Industry
ldu	Elementary/Secondary (0-12)	College (1-4	or 5+)			-		D 1-	1 C
်	12th grade	na		etter (al Ser
Be	17. Father's Name (First, Middle,	Last)			18. Mother's Nam			iumame)	
10	Ishmeal Polk				Madelin	e Wils	on		
To Be Completed by Funeral Director	19a. Informant's Name/Relationsh	nip <i>(Typ</i> e, <i>Pri</i> nt)	19b. I	Mailing Address (S	treet and Number or Rur	al Route Numbe	r, City or	Town, State, 2	Zip Code)
	Karen Sulliv	an-Sister	- 90	005 Oran	nge Hunt L	ane, A	nnar	ndale,	VA 23
	20a. Method of Disposition		20b. Place of [Disposition (Name, crematory or other	of !	Date	20c. Loc	ation - City or	Town, State
	1 Burial 2 Cremation	3 Removal from St	ate	-		100 100	<u>.</u>		77 - 1
	4 ☐Donation 5 ☐ Other (S)		Garris		est Vet 3/	22/06	OWlr	ngs Mi	IIS, I
SUCE	21. Signature of Funeral Service	Licensee A	MIL		F/H West				
O.	1 January	J. July	410	4300 W	abash Ave.	Balti	more	Md,	21215
	23a. Part1. Enter the disease, or shock, or heart failure. List	complication(s that cau only one cause on eac	wheel the death. Do not interest to the death.	ot enter the mode of	of dying, such as cardiac	or respiratory arr	est,		Approximate Interval Bety
n	Immediate Cause (Final disease or condition	Co	N6F55	IVE B	nel Isa	CHEM	11		Onset and D
1	resulting in death)	Due to (or	as a consequence of	f):		7 - 7	- Marie		24
r		. CA	RDIOL	740 P	ATHY				-/
<u>ē</u>	Sequentially list conditions, if any, leading to immediate	D	as a consequence of	/					
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
xa	resulting in death) Last	C	as a consequence of	f):					
caiE									
		d							
₹	IF FEMALE:	000 16 1100 01100	ome of pregnancy						
5	23b. Was decedent pregnant	1 Live birt	h 2 Fetal death	3 DEctopic pred	nancy		23	3d. Date of del Month	-
CO.	in the nast 12 months?								Dav i
sicia	in the past 12 months?		nt at time of death	5 Other (spec	ify)			MOHELL	Day Y
hysicia	1 ☐ Yes 2 😿 No 9 ☐ Unknown	9□ Unknow	'n						
y Physician/Med	1 ☐ Yes 2 🕱 No	9□ Unknow	'n					e contribute to	o the cause of d
þ	1 □ Yes 2 MNo 9 □ Unknowh Part II. Other significant condition	9□ Unknow	'n						o the cause of d
þ	1 □ Yes 2 MNo 9 □ Unknowh Part II. Other significant condition	9□ Unknow	'n				es 2	e contribute to	o the cause of d
þ	1 □ Yes 2 MNo 9 □ Unknowh Part II. Other significant condition	9□ Unknow	'n			1 🗆 Y 24a. Was a	es 2 🗆	e contribute to	o the cause of d robably 4 utopsy findings a completion of ca
	1 □ Yes 2 MNo 9 □ Unknowh Part II. Other significant condition	9□ Unknow	'n			1 🗆 Y 24a. Was a	es 2□	e contribute to	o the cause of d robably 4 utopsy findings a completion of ca
by	1 □ Yes 2 MNo 9 □ Unknowh Part II. Other significant condition	9□ Unknow	'n		se given in Part I. 26. Place of Deal	1 Yas autop perfor 1 Yes	es 2 an sy med? 2 No	e contribute to	o the cause of d robably 4 utopsy findings a completion of ca
e Completed by	1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant condition 25. Was case referred to medical	9 ☐ Unknow	'n	the underlying cau	se given in Part I. 26. Place of Deal	1 Yas autop perfor 1 Yes	es 2 an an sy med? 2 No	e contribute to	o the cause of d robably 4 topsy findings a completion of ca
To Be Completed by	1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No	9 Unknow	th but not resulting in the but not resulting	the underlying cau	se given in Part I. 26. Place of Deal	1 U Y 24a. Was a autop perfor 1 Yes h (Check only or	es 2 an sy med? 2 No ne) ence 6	e contribute to	o the cause of d robably 4 topsy findings a completion of ca
To Be Completed by	1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No	9 Unknow ons contributing to dea Hospital: 1 In Ing. 28a. Date of (Month)	th but not resulting in the but not resulting	the underlying cau	26. Place of Deal Other: 4 DNursing Ho	1 Y Y 24a. Was a autop perfor 1 Yes th (Check only or ome 5 Resid	es 2 an sy med? 2 No ne) ence 6	e contribute to	o the cause of d robably 4 topsy findings a completion of ca
To Be Completed by	1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Ing	th but not resulting in batient 2 ER/Outp Injury Day Year) In Injury - At home, farn	patient 3 DOA me of jury M	26. Place of Deat Other: Injury at Work? Up yes 2 \(\sum \) No	1 Y Y 24a. Was a autop perfor 1 Yes th (Check only or me 5 Resid 28d. Describe h	an syymed? 22 No	e contribute to	o the cause of d robably 4 to atopsy findings a completion of ca completion of ca
ertification; To Be Completed by	1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Ing	th but not resulting in batient 2 ER/Out, Injury 28b. Ti	patient 3 DOA me of jury M	26. Place of Deat Other: Injury at Work? Up yes 2 \(\sum \) No	24a. Was a autop perfor 1 Yes h (Check only or ome 5 Resid 28d. Describe h	an syymed? 22 No	e contribute to	o the cause of d robably 4 to atopsy findings a completion of ca completion of ca
Certification; To Be Completed by	1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 Vito 27. Manner of Death 1 Natural 5 Pendin 2 Accident investic 3 Suicide 6 Could determine the condition of the co	Hospital: 1 In Ing. 28a. Date of (Month, gation not be ined) 28e. Place of building	th but not resulting in batient 2 ER/Out, Injury Day Year) In Injury - At home, farm, etc. (Specify)	patient 3 DOA me of jury M m, street, factory, c	26. Place of Deal Other: 4 Nursing Ho Injury at Work? 1 Yes 2 No	24a. Whas a autop perfor 1 Yes th (Check only or me 5 Resid 28d. Describe h	an sy med? 22 No ne) ence 6 ow injury	e contribute to No 3 Pr 24b. Were au prior to death? 1 Yes Other (Spe occurred	o the cause of d robably 4 vitopsy findings a completion of ca 2 No
Certification; To Be Completed by	1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 Vito 27. Manner of Death 1 Natural 5 Pendin 2 Accident investic 3 Suicide 6 Could determine the condition of the co	Hospital: 1 Inguilation on the base in the	th but not resulting in patient 2 ER/Out, Injury 28b. Ti In If Injury - At home, farm, etc. (Specify)	patient 3 DOA me of jury M m, street, factory, c	26. Place of Deat Other: Injury at Work? Up yes 2 \(\sum \) No	24a. Was a autop perfor 1 Yes h (Check only or ome 5 Pesid 28d. Describe h City or Tow	an sy med? 2 No ne) ence 6 ow injury treet and m, State)	e contribute to No 3 Pr 24b. Were at an prior to death? 1 Yes Other (Spe occurred	o the cause of d robably 4 topsy findings a completion of case 2 No notify)
Certification; To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin investic 3 Suicide 4 Homicide determ 29a. Certifier (Check only one) 1 Certifyin 2 Medical	Hospital: 1 Ingration on the base and manner	th but not resulting in patient 2 ER/Out, Injury 28b. Ti In If Injury - At home, farm, etc. (Specify)	patient 3 DOA me of jury M m, street, factory, of death occurred at /or investigation, in	26. Place of Deat Other: 4 Nursing Ho Injury at Work? 1 Yes 2 No office	24a. Was a autop perfor 1 Yes h (Check only or me 5 Resid 28d. Describe h 28f. Location (S City or Tow and due to the cored at the time, co	an system of the state of the s	e contribute to	o the cause of depote the
ertification; To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin investigation investig investigation investigat	Hospital: 1 Inng gation not be ined 28e. Place obuilding Physician: To the bearing to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and th	th but not resulting in batient 2 ER/Out, Injury 28b. Ti Injury - At home, faring, etc. (Specify) rest of my knowledge, is of examination and or stated.	Datient 3 DOA me of jury M m, street, factory, of death occurred at for investigation, in	26. Place of Deat Other: 4 Nursing Ho Injury at Work? 1 Yes 2 No office the time, date and place, a my opinion, death occur	24a. Was a autop perfor 1 Yes h (Check only or me 5 Resid 28d. Describe h 28f. Location (S City or Tow and due to the cred at the time, of 2	an system of the state of the s	e contribute to	o the cause of d robably 4 utopsy findings a completion of ca s 2 No noify) ural Route Num. s stated. e to the cause(s th, Day, Year)
Certification; To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin investigation investig investigation investigat	Hospital: 1 Inng gation not be ined 28e. Place obuilding Physician: To the bearing to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and th	th but not resulting in batient 2 ER/Out, Injury 28b. Ti Injury - At home, faring, etc. (Specify) rest of my knowledge, is of examination and or stated.	Datient 3 DOA me of jury M m, street, factory, of death occurred at for investigation, in	26. Place of Deat Other: 4 Nursing Ho Injury at Work? 1 Yes 2 No office the time, date and place, a my opinion, death occur	24a. Was a autop perfor 1 Yes h (Check only or me 5 Resid 28d. Describe h 28f. Location (S City or Tow and due to the cred at the time, of 2	an system of the state of the s	e contribute to	o the cause of d robably 4 utopsy findings a completion of ca s 2 No noify) ural Route Num. s stated. e to the cause(s th, Day, Year)
Certification; To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin investigation investig investigation investigat	Hospital: 1 Inng gation not be ined 28e. Place obuilding Physician: To the bearing to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and th	th but not resulting in batient 2 ER/Out, Injury 28b. Ti Injury - At home, faring, etc. (Specify) rest of my knowledge, is of examination and or stated.	Datient 3 DOA me of jury M m, street, factory, of death occurred at for investigation, in	26. Place of Deat Other: 4 Nursing Ho Injury at Work? 1 Yes 2 No office the time, date and place, a my opinion, death occur	24a. Was a autop perfor 1 Yes h (Check only or me 5 Resid 28d. Describe h 28f. Location (S City or Tow and due to the cred at the time, of 2	an system of the state of the s	e contribute to	o the cause of d robably 4 utopsy findings a completion of ca s 2 No noify) ural Route Num. s stated. e to the cause(s th, Day, Year)
Certification; To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin investigation investig investigation investigat	Hospital: 1 Inng gation not be ined 28e. Place obuilding Physician: To the bearing to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and manner to the base and th	th but not resulting in batient 2 ER/Out, Injury 28b. Ti Injury - At home, faring, etc. (Specify) rest of my knowledge, is of examination and or stated.	Datient 3 DOA me of jury M m, street, factory, of death occurred at for investigation, in	26. Place of Deal Other: 41 Nursing Ho Injury at Work? 1 Yes 2 No office the time, date and place, my opinion, death occur	24a. Was a autop perfor 1 Yes h (Check only or me 5 Resid 28d. Describe h 28f. Location (S City or Tow and due to the cored at the time, of 2	an system of the state of the s	e contribute to	o the cause of d robably 4 utopsy findings a completion of ca s 2 No noify) ural Route Num. s stated. e to the cause(s th, Day, Year)

			For State	State of Marylar	nd / Depa	artmen	t of He	alth and		•		0 0 6	0834	8
			1 - State Registrar		Cer	TITICATE	e of De	eatn			Reg. No.	0 0 0		
	Physici	an	Decedent's Name (First, Middle, Last))					2.	Date of Dea Month	Day	Yea	3. Time of Dea	ath
	/Medic		Elizabeth Price		· · · · · · · · · · · · · · · · · · ·					23	11	06	3/117	
1	Examir	er	4a. Facility Name (If not institution, give	street arisi number)		4b. City,	Town or ke	ocation of De	ath		- 49	county of De		Ko
			5. Social Security Number 6. Se.		last hirthday)	If Under	1 Year II	f Under 24 H	Irs. R	Date of Birtl			Sirthplace (State or Fo	reign
	Funeral Director			DM 2⊠F 86	Yrs.	Months		Hours M	in.	(Month, Day	, Year)	920	Marvland	ii o igi i
			Usual Residence of Decedent						171	aren z	1:	920	Maryland	
	how		10a. State 10b. County	10c. Ci	ity, Town or Lo	cation							10d. Inside City Li	
	e Ma	cto	Maryland Baltimo	re	Towson								1 ☐ Yes 2 ፟	No
	다 다 0.28	Olre	10e. Street and Number			10f. Zip	Code				10g. Citiz	zen of What	Country?	
	23a	Funeral Director	1815 Putty Hill				1234				USA			
	er de	une	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. V	Vas Deced Yes, spec	lent of Hispa offy Cuban, I	anic Origin? Mexican, Pu	(Specify erto Ric	y Yes or No- an, etc.)	1	 Race - An Black, Wh 	nerican Indian, nite, etc.	
36	s aft	by F	1 ☐ Never Married 2XCXMarried 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 21☑ No If Yes, Give Year or Dates:	1	1□Yes 2	2 X No .	Specify:				Specify:	White	
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or lieme 23a or 28a-f ehow Ira Mudical Exarciline frinal be bidilited at	edk	15. Decedent's Edu		16a. Deced	ient's Usua	I Occupation	on		1	16b. Kir	nd of Busines	ss/Industry	
15	n n	plet	(Specify only highest grad Elementary/Secondary (0-12)	le completed)	(Give	kind of wor OO NOT us	rk done duri	ing most of w	vorking					
2	giene giene er the	Completed	6	College (1-4or 5+)	Hom	emake	r				70	wn Hom	e	
	be filed tal Hygi d other event, I	BeC	17. Father's Name (First, Middle, Last)				. 18	8. Mother's N	lame (F	irst, Middle,	Maiden .	Sumame)		
Maryland	should b nd Ments marked umatic e	To E	Conrad Boehmer					Lyc	lia	Dill				
al	2 sho and I e ma		19a. Informant's Name/Relationship (T)			-	•				-	Town, State	, Zip Code)	
	면들었는		Frank K. Price, S		_			1 Ave					21234	
ore	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F	Territoral Horn State	Place of Dispos cemetery, cren			į	Date		20c. Loc	cation - City of	or Town, State	
ᆵ	tant:		4 ☐ Donation 5 ☐ Other (Specify)		oudon P			_					, Maryland	
Baltimore,	permit. Pages 1 a Department of Hes Important: If item eny injury or othe once.		21. Signature of Funeral Service Lions		$\frac{22}{F}$. Name an unera	d Address of 1	of Facility Size	Ster	nsvil	le, :	on Sch Inc.	wab Witzke	5
	1010d		23a Part Enter the disease exemple		1	630 F	dmond	con Ax	7en11	e. Cat	Oner	ville,	MD 21228 Approximate	3
			23a. Part1. Enter the disease, or compleshook, or heart failure. List only o	ne cause on each line.			- /-	20	A S	sspiratory ari	iesi,	1 -	Interval Between Onset and Deat	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			perce		2-	10	, le	Cell	ze,	(Cello	8
	Examiner			Due to (or as a consec	quence of):	one	40	card	ral	Lay	xar	cron		
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consec	quence of):	7.	1	. /-					weeks	2
X	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Chrome	CB	EAR	chi	45				•	genes	_
0	e be executed sicien and e burial-transif		resulting in death) Last	Due to (or as a consec	quence of):									
3760		cal		d			 							
89	Attending Physicien: The law requires that the death certifical cloath. crobath. sctor: Atter this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE:											
Вох	ath ce ttend or us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1☐Live birth 2☐Feta	aldeath 3□	Ectopic pr					2	3d. Date of d Month	lelivery Day Year	,
	the a	yslc	1 ☐ Yes 2 02 No 9 ☐ Unknown	4□Pregnant at time of o	death 5∟	Other (spe	ecity)						•	
P.O.	that if	F.	Part II. Other significant conditions co	ntributing to death but not re-	sulting in the ur	nderlying ca	ause given i	in Part I.		23e. Did to	bacco us	se contribute	to the cause of death	h?
gg	uires tha signed Id be det									1 □ Y	es 20	No 3□	Probably 4 Unkr	nown
Vital Records,	w requir been si should	ete							_	24a. Was a	an	24b Were	autopsy findings avai	lable
Re	he ta e has age 2	Completed							-		med2	prior to death	o completion of cause ?	e of
ā	hysicien: The law his certificate has t I director, page 2 s	BeC	25. Was case referred to medical				20	6. Place of D	eath (C	1□ Yes		1 1 1	es 2□No	
	ysicii s cer direct	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3□ DO	Other					Other (Sp	pecify)	
0	g Phys ter this neral di		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		8c. Injury at Work?			I. Describe h			,	
Ö	endlr sath. or: Af he fur	atlc	2 Accident investigation	[,,	,	М		s 2□No						
Division of	or Attender de lirecte	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stre	eet, factory	, office		28f.	Location (S City or Tow			Rural Route Number.	
9	Hospital or 14 hours afte Funeraf DIr tely filled in													
1	To the Mospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical	29a. Certifier 1 ✓ Certifying Phy (Check only one)	sician: To the best of my kno iner: On the basis of examina and manner/stated.	owledge, death ation and/or inv	occurred a restigation,	at the time, in my opini	date and pla ion, death oc	courred	I due to the d at the time, o	ause(s)	and manner place, and d	as stated. ue to the cause(s)	
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	and mariner states.		29c	License n	umber			29d. Date	signed (Mo	nth, Day, Year	
	F ≯ F V		Calle	MID HID		D	000	31	23		m	arch	17801	5
	00	N.	30. Name and address of person who co	ompleted cause of death (ite	m 23a) (Tvne	Print)	1	2	^	2		Book	imero	nu.
	,4		CARLOS ET ARAI	VAGA, M.D.	5601	10	ch K	aulu	B	lud	105	6	17 Hal imere 1 21239	net
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature									
	Registr	ar	MAR 2, 0, 201	ns A	W A	200	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Day Year 4:32^{a M} Robert Stevenson Price March 19 2006 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Gilchrist Center Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Months 1 X M 2 □ F 350-14-8555 Yrs. 83 August 18, 1922 Illinois Usual Residence of Decedent 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 No Maryland Montgomery Burtonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3839 Dustin Road 20866 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 N Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 12 Research Physicist Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Charnley Price Bernardine Stevenson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jewell Price, Wife 3839 Dustin Road, Burtonsville, MD 20866 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metro Crematory March 20, 2006 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fleck Funeral Home 21. Signature of Nuveral Service Licensee Utin 7601 Old Sandy Spring Road, Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pancra fric Cancer nou fly Due to (or as a consequence of): Sequentially list conditions, I any leading to the class cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Monknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Funeral

Director

r 28a-f ehow

ral', or iteme 23a or Examiner must be

"natural".

d other then "nature event, the Medical E

Directo

Funeral

Completed by

Be

ဥ

the Maryland

filed within 72 hours after death

1 and 2 should be Health and Mental

27

Department of F Important: If Ite any Injury or of 9069.

Baltimore, Maryland 21215-0036

Examine physicien and s the burial-transit Completed by Physician/Medical ettending for use as signed by the e d be detached f hes After this certification funeral director, Certification: To Be Director:

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown

						1 Yes 20 No 1 Tes 20 HAD
25. Was case refer	red to medical				26. Place of D	Death (Check only one)
examiner?	No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 🗆 [OOA Other: 4 Nursing	Home 5 Residence 6 DOther (Specify) Claspic C
27. Manner of Deat 1 Matural 2 ☐ Accident	5 Pending investigation		28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stree	t, facto	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one)	1 Dertifying Ph 2 Medical Exam	yaician: To the best of my kn niner: On the basis of examina and manner stated.	uwledge, death o ation and/or inve	stigatio	d at the time data and plon, in my opinion, death or	occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier 220

29c. License number D0061199 29d. Date signed (Month, Day, Year) Mar. 19,2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6601 North Charks St. Touson MD 21204 Jason Black

MO

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

within 24 hours aft To the Funeral Di completely filled in

0

Medical

State Registrar

State of Maryland / Department of Health and Mental Hygiene | | | Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** 03-18-2006 Edward Prada 5:15 A /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Howard 12010 Little Patuxent Pkwy. Columbia If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 03-18-1922 Birthplace (State or Foreign Country)
 Mass 7. Age (In yrs. last birthday) 5. Social Security Number Sex X⊓M 2∏ F **Funeral** Months 84 Director 020.18.6741 Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 10b. County or 28a-f show Examiner must be notified at 1 Yes 2 No Howard Columbia Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21044 USA Little Patuxent Pkwy. Completed by Funeral 12010 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give 14. Race - American Indian, 11. Marital Status fited within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes X☐ No Specify: White Specify: 3 ☐ Widowed 4 🎖 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ? is marked other than "natur traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Electrical Engineer 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be finent of Health and Mental | ant: If item 27 is marked o Olive G. Vincent Prada 2 Frank E. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12010 Little Patuxent Pkwy. Columbia, Md 21044 Catherine E. Ward-- Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ö permit. Page Department of Important: If any injury or once. 3/20/2006 Metro Crematory Catonsville, Md 22. Name and Address of Facility Witzke Funeral Homes, 21. Signature of Funeral Service Ligensee ma \$555 Twin Knolls Rd. Columbia, Md 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final UREMIA Physician WEEK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CHRONIC KIDNEY DISEASE YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attanding Physician: The law requires that the death certificate be executed burial-transit POLYCYSTIC KIDNEY DISEASE that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) P.O. F signed by the at d be detached for Yes 2 No 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð pe : ARTERY DISEASE! ATRIAL FIBRILLATION; 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? HYDERLIPIDEMIA: TRANSIENT ISCHEMIC ATTACK FROM 24a. Was an was a... autopsy performs ? Yes 2 X No CEREBROVASCULAR DISEASE 1 ☐ Yes 2 ☐ No this certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after deat To the Funeral Director; 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medicet Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the state 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 38296 We WD MARCH 20, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8186 LARK BROWN ROAD, SUITESOI, SIKRIDGE, MD SIO75 GIBBONS MA 31. Date filed (Month, Day, Year) State MAR 2 0 2006 Registrar

d.	1.			State of Ma	rvland / De	partmen	t of Hea	alth a	nd M	ental Hyd	giene		00001	
		•	1 - For State Registrar		•	ertificat					Reg. No.	J6	08351	
	Disconiari		Decedent's Name (First, Middle	e, Last)						2. Date of Dea Month	Day	Year	3. Time of Death	
	Physici /Medic		Thelma L. Pay							March 8	3, 2006	6	7:47 P M	
1	Examin	er	4a. Facility Name (If not institution				Town, or Lo		Death			nty of Death		
			4619 Eastern Av		(In yrs. last birthd		Rani	_er f Under 2	4 Hrs.	8 Date of Birti			orge's	
	Funeral Director		577-50-0239	4 CT 14 - RT =	69 Yrs	Months		Hours	Min.	8. Date of Birti (Month, Day 07 25	y, _{Year)} 5 36		place (State or Foreign ntry) D.C.	
	D		Usual Residence of Decedent											
	arylan show	_	10a. State 10b. County		10c. City, Town o	Location							10d. Inside City Limits 1- Yes 2 □ No	
	Ba-f	Director		e Georges	Mt. Ra		-				10. 00	())(()		
	with the		10e. Street and Number			10f. Zip					10g. Citizen o		ntry?	
	eath is 23	eral	4619 Eastern	Avenue	ver in U.S. 1	3 Was Decer		anic Orio	in? (Spe	cify Yes or No-			can Indian.	
' 0	fer d	Funeral	1 □ Never Married 2 ☑ Marri	Armed Forces? ied 1 ☐ Yes 2 🖾 N		If Yes, spec	cify Cuban,	Mexican,	Puerto	Rican, etc.)	В	lack, White,	etc.	
93	ral', o	Ď	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2XI No 3	Specify:			Spec	cify: BIA	ICK	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show than cleal Examiliar maal ka notified at	Completed	15. Deceden (Specify only highe	t's Education st grade completed)	(G	ecedent's Usua ive kind of wo	rk done duri	on ring most	of worki	ng	16b. Kind of	Business/In	dustry	
121	han Dan	ם	Elementary/Secondary (0-12)	Colfege (1-4or 5-	+)	e. DO NOT u		۸ - a i			II C (~oo.*n	mont	
2	Hygie Hygie ther t		17. Father's Name (First, Middle,	5 yrs	. Adm:	inistra				(First, Middle.			ment	
Maryland	d be	To Be	John Lynch	,				He1	en (. Curt	İs			
3	shoul nd M	۴	19a. Informant's Name/Relations	hip (Type, Print)	19b. M	ailing Address	(Street and					vn, State, Zij	c Code)	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat mark to rollified at ances.		Jock Payne/So	n	6816	Nashv	ille.	Koad	, La	uham, 1	D. 207	706		
Baltimore,	ges 1 t of H if iter or oth		20a. Method of Disposition 1 Surial 2 Cremation	3 Removal from State		crematory or o	ther place)			ate				
ij	int. Pag artment ortant: injury c			StBurial 2 □ Cremation 3 □ Removal from State □ Cometery, crematory or other place) MD. National Cem. □ 03-14-06 □ Laurel, MD.										
Ba	Depa Impo any i		22. Name and Address of Facility Marshall & Fuller at Home 4217 9th. St. N.W. Washington, D.C. 20011											
			23a. Part Enter the disease, or	complications that caused	the death. Do not								Approximate	
4	Physician		shock for heart failure. List fmmediate Cause (Final	•			An In		Me	(1110	2 010	700	Onset and Death	
1	/Medical		mmediate cause (rinal lisease or condition esulting in death) a. ATHEROSCIEROTIC CARDIOVAS WAR DISEASE Due to (or as a consequence of):											
	Examiner		Cognosticilly list conditions	equentially list conditions, b.										
	ש ב	ner	if any, leading to immediate cause. Enter Underlying		i consequence of).									
	ecute and -trans	каш	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to for as a	consequence of):									
3760,	te be executed ysician and ie burial-transit	cal Examiner			i odnodadnod dry.									
687	ficate p physis the	_		d							т.			
Box	death certifica e attending ph d for use as th	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		2 🗀 🖛					23d. l	Date of deliv	ery	
Ö.		Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant at 9□Unknown		3 □Ectopic pr 5 □ Other (sc					1	Month	Day Year	
P.O.	d by ti	Phy	9 Seqknown Part II. Other significant condition		et ant reculting in th	o undorhing o	auga givon	in Dort I		23a Did to	obacoo uso co	natributa to t	the cause of death?	
ds,	The law requires that the ate has been signed by th page 2 should be detache	d by	Part II. Other significant conduct	one contributing to death be	ic not resulting in th	e anoenying c	ausa givari	mr carti.			/es 2 □ No		١.	
Vital Record	w requir been s should	Completed				-				24a. Was	an 24	b. Were auto	onsy findings available	
Re	he lay e has ige 2	E G								autop	rmed?	prior to co death?	empletion of cause of	
tal	an: T tificat tor. p	BeC	25. Was case referred to medica	l l			2	26. Place	of Death	Check only o	2 No	Town, State, Zip Code) 20706 Sation - City or Town, State cel, MD. neral Home D. C. 20011 Approximate Interval Between Onset and Death SEASE 3d. Date of delivery Month Day Year se contribute to the cause of death? No 3 Probably 4 Minknow 24b. Were autopsy findings available prior to completion of cause of death? 1 20 ss 2 No 20ther (Specify) SCENE Townsor		
<u>></u>	Physician: this certific ral director.	To E	examiner? 1 ∑Yes 2 ☐ No	Hospital: 1 [fnpatie	nt 2 🖺 ER/Outpa	itient 3 DC	Other:	4 □ Nur	sing Ho	me 5∐Resid	dence 6 🕱	Other (Speci	_{fy)} scene	
n of	ding Physician: The lav h. After this certificate has funeral director, page 2		27. Manner of Death 1 Natural 5 □ Pendir	28a. Date of Injur (Month, Day	y 28b. Tim Ye <i>ar)</i> Inju	ry	28c. Injury at Work?			28d. Describe h	now injury occ	curred		
sio	Attending ir death. ector: After by the fune	catl	2 ☐ Accident investi	not be	A45	М		s 2 □ N	-	296 Location /	Street and Min	mhas as Dua	- Doute Number	
Division	or Attendate death Director:	Certification:	4 Homicide determ	building, etc	ry - At home, farm . (Specify)	, street, ractor	y, office			City or Tov		IIIDer or Aur	ar noute wattiger,	
	o the Hospital or Attendinin 24 hours after death of the Funeral Director: completely filled in by the		29a. Certifier 1 ☐ Certifyii	ng Physician: To the best of	of my knowledge, d	eath occurred	at the time,	date and	d place,	and due to the	cause(s) and	manner as	stated.	
	the Ho in 24 the Fu	edical	5/16/	Examiner: On the basis of and manner sta	ted.				h occurr	ed at the time,	date and plac	e, and due t	to the cause(s)	
	To the within To the	Σ	29b. Signature and title of certifie	r		296	c. License n	number			29d. Date sig	ned (Month,	Day, Year)	
,	101		- unex				CME				March	9, 200	06	
(1		30. Name and address of person	who completed cause of de	eath (Item 23a) (Ty		D	7.		D_1. *	36	1 .	1 01 001	
7	Sta	ite	31. Date filed (Month, Day, Year)		r's Signature			stree	ег,	<u>Baltimo</u>	re, Ma	rутапо	1 41401	
	Regist		MAR 2 (2006	r's Signature	Service of the servic								

			1 = For State Registrar	State of Man		artment of F			iene _{og} No. 06	08352
	Physici	20	1. Decedent's Name (First, Middle, Last,					2. Date of Deat Month	h Day Year	3. Time of Death
	/Medic			Joseph Lee	e Ritch			3	15 2006	1 . 00 11
1	Examin	er	4a. Facility Name (If not institution, give Future Care Home)			4b. City, Town, or Balto	r Location of Death		4c. County of De	ath
	Funeral		Social Security Number 6. Security Number	7. Age (/ YM 2□F	n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign country)
	Director		238-48-5384 Usual Residence of Decedent	A.W. 2	74 Yrs.			5-5-19		N.C.
	tied within 72 hours after death with the Maryland Hyljone. Ither than "natural", or Iteme 23a or 28a-f ehow ent, the Medical Examinar must be notified at		10a. State 10b. County	10	Dc. City, Town or Lo	ocation				10d. Inside City Limits
	be filed within 72 hours after death with the Marylan dai Hygiene. dai Hygiene. dai Hygiene. dai Hygiene. dai Hygiene. dai Hygiene. daine Madical Examinar must be notified at event, the Madical Examinar must be notified.	to	Md	A	Balto					Y☐Yes 2☐No
	th the	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What C	Country?
	23a (23a)		2921 Ulman Avenu	e		21	1215		USA	
	r dez	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	ar in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
36	s afte , or li	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1vTYes 2 ☐ No If Yes, Give		1□ Yes 2√√ No	Specify:			Black
Ö	hour ture!	q pa	15. Decedent's Edu	Year or Dates:		dent's Usual Occup	ation		16b. Kind of Busines	
5	in 72	Completed	(Specify only highest grad	e completed)	(Give	kind of work done of DO NOT use retired	during most of work	ting	Bethleher	,
212	with jiene ther	mo	Elementary/Secondary (0-12)	College (1-4or 5†)	/A	Heater He	lper		BetilTellei	n steer
פַ	0 = 0 5	Bec	17. Father's Name (First, Middle, Last)					e (First, Middle, M	Maiden Surname)	
ylar	2 should be and Mental I marked o	To E	Willie Lee Ritch					e Pope		
Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked eny Injury or other traumatic sonce.		19a. Informant's Name/Relationship (Ty Joseph Junior Rit	,		ng Address (Street . 1 Ulman A		al Route Number, alto, MD	City or Town, State,	Zip Code)
	1 and Healt tam 2		20a. Method of Disposition		20b. Place of Dispo	sition (Name of			20c. Location - City o	r Town, State
ē	Pages nent of int: If It		taBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	-	matory`or other plac .11e Vet (Crownsvil:	
altimore,	artme ortar injur		21. St natur Huneral Service Licens	ee /) //		2. Name and Addres				re, mu
ñ	De de de de de de de de de de de de de de		1 running	UNTU	MIX	4300	Wabash		Balto, Md	21215
			2: a. Part / Enter the disease, or complishork, or heart failure. List only or	ications that daused the	death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Pnysician		In mediate Cause (Final disease or condition		1100	mids				Onget and Death
	/Medical Examiner		resulting in death)	Due to (or as a c	onsequence of n	16	2			0 000,70
	CXAIIIIIIei	_	Sequentially list conditions,	Due to (or as a c	[w	men fair	llure			e.
	red nsit	Examiner	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cr	orisequence or):	ruluto				62
	cate be executed physician and the burial-transit	Exar	that initiated events resulting in death) Last	Due to (or as a co						
8760,	sicia Sicia e buri	dical		1.						
9	tificat g phy as th	Medi								
Box	eath certific attending p	cian/Me	23b. was decedent pregnant	3c. If yes, outcome of p		Ectopic pregnancy	,		23d. Date of de	
	at the dea by the at rached fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at tim 9☐ Unknown		Other (specify)			Month	Day Year
P. 0.	The law requires that the death certificate be executed tate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physi	Part II. Other significant conditions cor	atributing to death but o	ot resulting in the u	ndarhina anusa anu	on in Port I	23a Did tob	azona uso contributo	to the cause of death?
Vital Records,	ires that signed t d be det	Ď	Nurhu		la di		eri ili Faliti.	1 ☐ Ye		Probably 4 Unknown
Ö	w require been si should b	etec				0.5(-		
He Ke	The lav	Completed					-	24a. Was ar autopsy perform	v prior to	utopsy findings available completion of cause of
ā	ician: Th certificate rector, pag		25. Was case referred to medical				OC Disease of Print	1 ☐ Yes 2	. □No 1 □ Ye	s 2□No
>	/sicia s cent direct	o Be	examiner?	lospital:	2 ER/Outpatier	nt 3 DOA Othe	or.	h Check only one	nce 6 ∐Other (Sp	aciti)
0	g Phy ter thi	ı.	27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Time of		7.700		w injury occurred	ocny)
Š	endin sath. or: Afr	atio	1 ☑Natural 5 ☐ Pending investigation	(Month, buy 11	bar/ Injury		Yes 2 □No			
Division of	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (S	- At home, farm, str Specify)	eet, factory, office		28f. Location (Str City or Town	reet and Number or F , State)	Rural Route Number,
	pital ours a eral C		29a. Certifier 1 ☐ Certifying Phys	sician: To the best of m	u kasuladas dasil		- data and alass			
	To the Hospital or Attending Physician: within 24 hours after death as a set death ins certifica To the Funeral Director: After this certifica completely filled in by the funeral director, it	Medical	(Check only 2 Medical Exami	ner: On the basis of ex and manner stated	amination and/or in	vestigation, in my of	pinion, death occur	red at the time, da	ate and place, and du	e to the cause(s)
	To the To the comp	ž	29b. Signature and title of certifier	į.		29c. License			9d. Date signed (Mon	
	1			a	S	()	27569		2016/0	5
5	1		30. Name and address of person who co	empleted cause of death	h (Item 23a) (Type,	Print)	i V	26 6	23/16/00	T. 121
	- 0		31. Date filed (Month. Day Year)	32 Penistraria	Signature Signature	mun	18	0 01	eene	NU 171
	Sta Registr	ie ar	31. Date filed (Month, Day, Year) 20	06 32 negistrar's	The by					

ner	cine Ro	ser	For	State of M	aryland					Mental Hy	giene	3	m nee Fi
			1 - State Registrar	.1		Cei	rtificate	of De	eath	2. Date of De	Reg. No.	16 [18353
п	Physici	an	Decedent's Name (First, Middle, Last								ch 17,	2006	3. Time of Death 7:20 P M
	/Medio Examir		Catherine Rosentl 4a. Facility Name (If not institution, give)		4b. City, Tox	wn, or Lo	cation of De		4c. Cou	nty of Death	
			339 Stratford Road						ville			TIMORI	
	Funeral Director		5. Social Security Number 6. Social Security Number 1 212-05-0038 Usual Residence of Decedent	9x 7. Ag □ M 2 Ø F	ge (In yrs. Ia 96	st birthday) Yrs.	If Under 1 Y Months D		Under 24 H lours Mi	n. (Month, Da	th ly, Year) /1909	9. Birthp Coun Mary	place (State or Foreign htry) land
	yiand tow		10a. State 10b. County		10c. City,	Town or Lo						1	Od. Inside City Limits
	e Man	ctor	MD Baltimo	ore			Cato	nsvi	lle				1 ☐ Yes 2 Z No
	with th	Dire	10e. Street and Number				10f. Zip Co				10g. Citizen		ntry?
	leath o	erai	339 Stratford Roa	12. Was Decedent	Ever in U.S	. 13. 1	Was Deceden	2122 t of Hispa		(Specify Yes or No erto Rican, etc.)	U.S.A	A . Race - Americ	ean Indian,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Depertment of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28e-f ehow any folury or other traumatic event, the Medical Examinar must be notified at ance.	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces' 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No		If Yes, specify		Mexican, Pur Specify:	erto Rican, etc.)	Spe	slack, White, cify: Wh	etc. ite
Baltimore, Maryland 21215-0036	72 ho naturi dical l	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)		16a. Dece	dent's Usual C kind of work of DO NOT use r	ccupation	n ng most of w	vorking	16b. Kind of	Business/Inc	dustry
121	within ane. than	idu	Elementary/Secondary (0-12)	Coflege (1-4or	5+)		<i>00 NOT</i> use <i>i</i> lephone				Commi	ınicat	ions
2	Hygie other	Be Co	17. Father's Name (First, Middle, Last)			16	rephone	7-		lame (First, Middle			10113
/lan	uld be Mental irked itic ev	To B	George F. Albrech	nt]	31anch	e R. Hop	kins		
lan,	2 sho and 1 is ma		19a. Informant's Name/Relationship (7		-					Rural Route Numb			
e, N	1 and Heelth em 27 ther ti		Wayne Rosenthal -	- Son	20b. Pla		Stration (Name matory or other		Road	Catonsv		n - City or To	
TOT.	ages ant of nt: if it y or o		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		7 i				rk 3/2	21/2006		ige, M	
al‡	mit. F pertme portar ortar / Injur		21. Signature of Funeral Service Ligen	CO-CT	Mead	OW L 10	2. Name and A	Address o	Facility S	terling,			
<u> </u>	Depe Impo any to		* Osmandi	alros	the	Ä	ve. Ca	tons	ville,	ambn 2122	8, 1116	. 105	b-Witzke O Edmondsor
8760, 水	Physician / Medical Examiner properties of the print-transit p	licai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. ATHEROSCU Due to (or as b. Due to (or as c. Due to (or as d.	s a conseque	ence of):	s (vega Ns	SEASK	Compli	untedby Asia	ATTON CF V	OMITUS	
P.O. Box 68	death certific e ettending p od for use es	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. ff yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal o	death 3[Ectopic pregi					Date of delive	ery Day Year
	res that the de signed by the e be detached f	by PI	Part II. Dther significant conditions c	ontributing to death I	but not resul	ting in the u	nderlying caus	e given i	n Part I.	23e. Did			ne cause of death?
ord	w require been sl	eted								-	Yes 2		ably 4 Unknown
al Records,	The la	Completed									psy prmed? 2 \(\sum No	b. Were auto prior to co death? 1 XYes	psy findings available mpletion of cause of 2 No
Xi	Physician: T r this certificat ral director, pa	9 Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	Hospital:	005	D/Outpaties		Other		Home 5 Res		Dub (7) (1)	
o	g Phy er this eral d	n: To	27. Manner of Death	1 ☐ fnpati 28a. Date of Inj (Month, Da	urv :	R/Outpatier 28b. Time o		Injury at Work?		28d. Describe	how injury occ	curred	
ion	Attending in death.	atio	1 Natural 5 Pending 2 Accident Investigation	3/12/	06	Injury 185	7 м	1 Yes		5085E	VOMIT	SPIRAT	
Division of Vital	after death after death Director: d in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	280. Place of in	njury - At hon tc. (Specify)			_		28f. Location (Street and Nu	mber or Rura	RATEURD
_	To the Hospitel or Attending F within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer.	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis	of examination	ledge, deat	10ME h occurred at I vestigation, in	the time,	date and pla on, death oc	ice, and due to the	cause(s) and date and place	manner as s	tated.
	within To the	Me	29b. Signature and title of certifier	1			29c. L	icense nu	mper		29d. Date sig	ned (Month,	Day, Year)
	./		· //	1	>			0.	C.M.E	•	Mar	ch 18,	2006
	b		30. Name and address of person who		death (ftem	23а) (Туре,							
	Sta	ate	31. Date filed (Morith, Day, Year)	32. Regist	trar's Signatu	ıre		Penn	Stree	et Baltin	nore, M	aryıan	IC ZIZUI
25	Regist		MAR 2. 0. 2		CASS A	de de	rack						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 6:43 AM Wilbur Justus Reitze March 16 2006 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Broadmead Cockeysville If Under 1 Year | ff Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 X M 2 □ F 93 215-07-1654 July 10 Director 1912 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examinest must be notified as once. 10a. State 10b. County 1 ☐ Yes 2 X No Baltimore Cockeysville Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13801 York Rd. 21030 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 1943 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify 3 ₩ Widowed 4 Divorced 1943 white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education Willowy Action (Specify only highest grade completed) Elementary/Secondary (0-12) Colfege (1-4or 5+) petroleum sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edna Hanley Justis Reitze 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) David Reitze/son 1807 Port 0'Call TX77554 Galveston, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Greenmount crematory Mar. 17,2006 Baltimore. Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
Raltimore, MD 21212 21. Signature of Funeral Service Liçensee John O. Mito Baltimore, MD 23a. Ant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (ir as a consequence of) Division of Vital Records, P.O. Box 68760 Physiclan/Medical use as the the attending phed for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by should be 2 12 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2 1 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospitaf: 1 ☐ Inpatient 1 Yes 2 No 4 Unursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Aiter Injury 1 DNatural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I To the Hospital 1 & certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Qay, Year)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

20

of death (Item 23a) (Type, Print)

32. Registrar's Signature

		•	For State Registrer	State of Ma		partment o	f Health and N of Death	Mental Hygie	2006	08356
	Physici		1. Decedent's Name (First, Middle, La Stanley G Speci					84 0 0 0 11	Day Year 15 2006	3. Time of Death
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, gives 5. Social Security Number 6. S. 215-40-4282	HOSPITA	(In yrs. last birthda 63 yrs	ay) If Under 1 Y	m, or Location of Death A H M O I ear If Under 24 Hrs. ays Hours Min.		4c. County of Death	N/A nplace (State or Foreign MD
	ש	70	Usual Residence of Decedent 10a. State 10b. County MD	N/A	10c. City, Town or Balt	Location				10d. Inside City Limits ty Yes 2 □ No
	with the M a or 28a-f	Directo	10e. Street and Number 3603 W Mulbers			10f. Zip Co	de 21229	10g.	Citizen of What Co	untry? USA
336	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Itams 23e or 28e-f show important: if Item 27 is marked other then "naturel", or Itams 23e or 28e-f show important; if Item 27 is mortified at any Injury or other traumatic event, the Modical Examiner must be notified at ances.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:		3. Was Decedent If Yes, specify	of Hispanic Origin? (S Cuban, Mexican, Puert No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify: B]	e, etc.
21215-0036	d within 72 hou jiene. ir then "nature the Medical E	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 1 2 th		(G lif	ocedent's Usual O ive kind of work d e. DO NOT use n erk	one during most of wor	king	Johns Ho Hospital	pkins
Maryland 2	ould be filed Mentat Hygi- arked other atic event, it	To Be C	17. Father's Name (First, Middle, Last Gelister Speic				Pearl	ne (First, Middle, Mair Williams	5	
	and 2 should lealth and Men m 27 is marke her traumatic		19a. Informant's Name/Relationship Katie Speight		360	3 W Mul	berry St	Baltimo	re MD 21	229
Baltimore,	Peges 1 ment of He ant: If Iten ury or oth		20a. Method of Disposition ↓□Burial 2 □ Cremation 3 [4 □ Donation 5 □ Other (Special Content of the Content	☐Removal from State	cometen		Park 3/2	21/06 Ra	andallst	own
Balt	permit. Peg Depertment Important: eny Injury o		21. Signature of Funeral Service Lice	us		5240 Re	eistersto	wn Rd Ba		
	Physician /Medical		23a. Part 1. Enter the disease, or con shock, or usart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lin	the death. Do not e. C + a consequence of):		dying, such as cardiad	or respiratory arrest,		Approximate Interval Between Onset and Death Mount In
	Examiner	mlner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	a cons uence of:	RD 1				Years
8760,	icate be executed physicien and s the burial-transit	dical Examin	that initiated events resulting in death) Last	Due to (or as a	a consequence of):					
P.O. Box 6	deeth certif le ettending ad for use a:	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic pregr 5 □ Other (specif			23d. Date of deli Month	ivery Day Year
	e ig e	Ď.	Part II. Other significant conditions	contributing to death bu	ut not resulting in th	e underlying caus	e given in Part I.	23e. Did tobac		the cause of death? obably 4 Unknown
I Reco	The law rete hes be	Completed						24a. Was an autopsy performed	d? death?	itopsy findings available completion of cause of 2 ☐ No
Vita	Physicien: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospitaf:	•		Othor	ath <i>Check only one</i> Iome 5 Residenc	a 🗆 Out	
o		5 :r	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injur (Month, Day		atient 3 DOA le of 28c.	Injury at Work?	28d. Describe how		City)
Division of Vital Records,	To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After completely filled in by the funer	Certification:	1	on Diese of Init	ury - At home, farm	М	1 ☐ Yes 2 ☐ No	28f. Location (Stree City or Town, S	at and Number or Ru State)	ural Route Number,
	he Hospit in 24 hour he Funera pletely fille	edical		hysicien: To the best ominer: On the basis of and manner sta	examination and/o			urred at the time, date	and place, and due	to the cause(s)
	To t withi To tl	×	29b. Signature and title of certifier	ry Vinja	maran		P1745		Date signed (Monta)	
(2		30. Name and address of person who	VINJAMA	FRAM	700 C	P1745 aton Ave	Balton	rose, mi	21229
	St	ate	31. Date filed (Month, Day, Year)		ar's Signature	1 .				£

DHMH 17 Rev 1/2001

STANLEY G.

ORIGINAL

		1	For State Registrar	State of Maryland		rtment of He			ene 92006	08357			
			Decedent's Name (First, Middle, Last)			<u>*,</u>		2. Date of Death Month	Day Yea	3. Time of Death			
	Physicia	_	Joseph Edgar Su	bock					18, 2006	8:42 A.M			
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Deatl	h	4c. County of D	eath			
		2	St. Agnes Hospi	tal		Balti							
	Funeral Director		5. Social Security Number 6. Sex 1 🗵	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, March 26	Year)	Birthplace (State or Foreign Country) [aryland			
	D *		Usual Residence of Decedent 10a. State 10b. County	10c. City, 1	Γown or Lo	cation				10d. Inside City Limits			
	faryla e d al	_			tons					1 ☐ Yes 2 No			
with the h	the N	Funeral Directo	Maryland Baltimore	i Ga	LUIIS	10f. Zip Code		10	g. Citizen of What	Country?			
	3a or	٥	10 Holmes Avenue		21228			USA					
	death ms 2	Jera		12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of His f Yes, specify Cubar	spanic Origin? (S	Specify Yes or No-		mencan Indian, hite, etc.			
36 Seffer	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f show says injury or other treumatic event, the Medical Examinar must be notified at once.	þ	1 Never Married	1 XYes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🂢 No	Specify:	,	Specify: W				
Ö	2 hou	Completed	15. Decedent's Edu (Specify only highest grade	rking	6b. Kind of Business/Industry								
21	thin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		0							
2	ed will ygien ygien th	Co	8			Laborer	18 Mother's Na	me (First, Middle, M	Construc	ction			
Maryland 21215-0036	ibe fil ntat H od oth	Be	17. Father's Name (First, Middle, Last) Harry E. Subock					e Krickba					
ž	hould d Mer mark matic	2	19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Mailir	ng Address (Street a				e, Zip Code)			
<u>B</u>	d 2 s Ith an 27 ie treui		Margaret H. Subock			lmes Aven							
ē,	Heal Heal tem 2	li	20a. Method of Disposition	20b. Plac	e of Dispo	esition (Name of matory or other place	1		20c. Location - City				
JOH L	ages ant of it: if i		1 ZBurial 2 ☐ Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify)			ge Mem. P		2/2006 E	lkridge,	Maryland			
Baltimore,	ortar		21. Signature of Funeral Service Licens		2	Name and Addres	s of Facility St	erling As	hton Sch	vab Witzke			
ä	Depa impo eny ir		> debuce	de.	1	Funeral H 630 Edmor	lome of d ldson Av	Catonsvil enue; Cat	onsville	MD 21228			
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	c or respiratory arre	est,	Approximate Interval Between Onset and Death							
	Physician /Medical		disease or condition resulting in death)	Bue to (or as a conseque		1				4 years			
	Examiner			Diabetes Mellitis 2 years									
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):									
r	cuted nd ransii	ami	Cause (Disease or injury that initiated events c.										
Ö,	cate be executed physicien and the buriat-transit	icai Examiner	resulting in death) Last	Due to (or as a conseque	nce of):								
8760,	physic physic s the b			d									
Box 6	death certificate be executed e attending physicien and nd for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnand	leath 3{	∃Ectopic pregnancy			23d. Date of	delivery Day Year			
P.O. E	that the dea ted by the at detached fo	hysici	1 Yes 2 No 9 Unknown	4 □ Pregnant at time of dea 9 □ Unknown	ith 5[Other (specify)							
	res that igned b	by P	Part II. Other significant conditions co	ntributing to death but not result	ting in the t	inderlying cause give	en in Part I.			te to the cause of death?			
prd	v require been sig		Obesity				1691	es 2□No 3[Probably 4 Unknown				
Records,	e tay has	Completed						24a. Was a autops perfori	med? prior	e autopsy findings available to completion of cause of the Yes 2 No			
Vital		a	25. Was case referred to medical				26. Place of De	eath (Check only or	ne)				
<u> </u>	S 50	To B	examiner? 1 ☐ Yes 2 🔯 No	Hospital: 1 ☐ Inpatient 2 🔀 E	R/Outpatie	nt 3 DOA Oth	Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
o uo	Afte fune		27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of North, Day Year) 28c. Injury at Work? 1 Yes 2 No									
Division of	il or Attending after death. I Director: Afte d in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, larm, s	treet, factory, office	office 28f. Location (Street and Number or Rural Route Number City or Town, State)						
_	Hospite 14 hours Funeral tely fille	Medical C	29a. Certifier (Check only one) 20a. Certifier (Check only one) 20a. Certifier (Check only one) 20a. Certifier (Check only one) 20a. Certifier (Check only one) 20a. Certifier (Check only one) 20a. Certifier (Check only one) 20a. Certifier (Check only one) 20a. Certifier (Check only one) 20a. Certifier (Check only one) 20a. Certifier (Check only one) 20a. Certifier (Check only one) 20a. Certifier (Check only one) 20a. Certifier (Check only one) 20a. Certifier (Check only one) 20a. Certifier (Check only one) 20a. Certifier (Check only one) 20a. Certifier 20a. Certifier 20a. Certifier 20a. Certifier 20a. Certifier 20a. Certifier 20a. Certifier 20a. Certifier 20a. Certifier 20a. Certifier 20a. Certifier 20a. Certifier 20a. Certifier 20a. Certifier 20a. Certifier 20a.										
	To the vithin 2 To the comple	Med	29b. Signature and title of certifier	and manner stated.		29c Licens	number		29d. Date signed (#	Month, Day, Year)			
•			30. Name and address of person who	completed cause of death (Item	23a) (Type	, Print)	0010		241 R	Miller			
_	6+1		405 F	redorick	RC	d Ske	210	cation.	sville	UP,			
(a)	St Regist	ate trar	31. Date filed (Month, Day, Year) MAR 2 0 2006	32. Registrar's Signati	Jre Spa	K							

			1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of H	lealth and N Death	Mental Hygie	Case Co. In C.	5 08	358		
			1. Decedent's Name (First, Middle,	Last)				2. Date of Death			Time of Death		
	Physici		William	Robert	Smith ,	Jr.		MONTH	-	rear 6	:45 PM		
>	/Medic Examir		4a. Facility Name (If not institution,		DMIZOII (_	Location of Death		4c. County of	~ _			
	Exami	ier			A				4c. County of				
_			SINAI HOSPITA 5. Social Security Number 6		ALTIMPRE (In yrs. last birthday)		IMORE If Under 24 Hrs.	8. Date of Birth		City			
	Funeral Director			11XM 2□ F		Months Days	Hours Min.	(Month, Day, Y	ear)	Country)	State or Foreign		
	Director		212-07-1799 Usual Residence of Decedent	87				Dec.8,19	18	Balto.	Md.		
	and *		10a. State 10b. County		10c. City, Town or Lo	ocation				10d In	side City Limits		
	dary h	ō	25.1	City							X Yes 2 □ No		
	Ne 188	ect.	Md.		Bai	ltimore 10f. Zip Code					A) 163 2 110		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heatile and Mental Hygiene. Depertment: If teem 27 is marked other then "naturel" or items 23a or 28a-f show important: If teem 27 is marked other then "naturel" or items 23a or 28a-f show eny Injury or other traumatic event, the Madical Examiner must be notified at page.	ai Director	10e. Street and Number 7012 Lancas	Citizen of Wh. USA	Citizen of What Country? USA								
	dear dear	Funeral	11. Marital Status	12. Was Decedent E		Was Decedent of Hi	spanic Origin? (Sp	ecify Yes or No-	14. Race -	American Inc	dian,		
2		Ē	1 Never Married 2 Married	Armed Forces? XXYes 2 □ N If Yes, Give	lo	If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black,	White, etc.			
	hours after turel', or tte al Examine	Ď	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 1	1941-1945	1□ Yes 2∏ No	Specify:		Specify:	Wh:	ite		
5	e in	Completed	15. Decedent's			dent's Usual Occupa	ation	161	b. Kind of Busi	norc/Industry			
2	in a	Set 1	(Specify only highest	grade completed)	(Give	kind of work done of DO NOT use retired	turing most of work	ing	J. Kilia di basi	nessindasiry			
7	the sta	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5-	+)		,		Constr	uction			
7	oe filed within 72 to all Hygiene. I other then "naturent, the Medica		11 th Grade 17. Father's Name (First, Middle, La	et)		le Setter	40 14-4-4-1						
2	d la d	Be		•			18. Mother's Nam	e (First, Middle, Mai	den Sumame)				
2	Mer Sta	ြိ	William R. Smi			,	Augu		Priester				
Mai	2 should be f n and Mental I le marked of raumatic eve		19a. Informant's Name/Relationship					al Route Number, C)		
Ξ	end a		Mrs. Ena R. Smi	th (Wife)	7012	Lancaster	r Road	Baltimore	, Md. 2	21207			
ש	of He d	-	20a. Method of Disposition		20b. Place of Dispo	sition (Name of		Date 20d	c. Location - Ci	ity or Town, S	tate		
2	Pages nent of int: If It iry or o		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		1	matory or other place	1	1 00 06		33			
	nita nita		21. Signature of Funeral Service Lice			Forest V.		ch 22,06					
8	permit. Depertr Import		21. Signature of Purieral Service Cit	D /		2. Name and Addres	conce establishment	11824 Re					
	20200		23a. P1rt1. Enter the disease, or co	time				Reisters		1d. 211	136		
ı	Into law requires that the death certificate be executed X	dical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or se s	a consequence of):	card		nfacet	nie o	4	gays		
0	phy sth	큣											
	ne death certific the attending p thed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23d. Date of delivery Month Day Year									
Ė	d by letac	P		and the sign to do the				1					
5	w requires that the dis been signed by the should be detached	ed by	Part II. Other significant conditions	2 No 3 Probably 4 Unknown									
3	sho sho	Completed						24a. Was an	24h W/o		diana available		
2	has ge 2	Ē						autopsy	pric	or to completion	ndings available on of cause of		
3	cate							1 ☐ Yes 2 🔀		Yes 2001	ło		
	ician: Inelay certificate has rector, page 2	Be	25. Was case referred to medical examiner?	Dr. Set				h (Check only one)					
	his c	မ	1 ☐ Yes 2/8 No	Hospital:		t 3 DOA Othe	or: 4 ☐ Nursing Ho	me 5 🗆 Residence	e 6 □Other	(Specify)			
- 1	fter 1	Ë	27. Manner of Death 1.★Natural 5 □ Pending	28a. Date of Injury (Month, Day	y 28b. Time of Year) Injury	28c. Injury Work	at ?	28d. Describe how i	e how injury occurred				
2	ath. Fr: A	ati	2 Accident investigat				res 2□No						
2	oy th	<u>₹</u>	3 Suicide 6 Could not	ed 286. Place of Injui	ry - At home, farm, str	eet, factory, office		28f. Location (Stree	t and Number	or Rural Rout	e Number		
5	afte Diri	Certification;	4 Homicide determine	building, etc.	. (Specify)			City or Town, S	tate)				
	I of the hospital of Atlending Prystoten: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best of aminer: On the basis of	examination and/or in	n occurred at the tim	e, date and place, inion, death occurr	and due to the caus	e(s) and mann	er as stated.	ause(s)		
	the sld	Med		and manner stat	led.								
	2 4 5 9	_	29b. Signature and title of certifier			29c. License		1	Date signed (/				
	1		Heure.	nce N	1D	RE.	5-00	0	ARCH	12 -	2001		
1	1/	3	30. Name and address of person wh	o completed cause of de		Print)		0 M	11-2-1	1	006		
	-		Komal Law	15 1 1 A	D. 8.10.	a. Ho	EITA.	- 06	80	Exerci-	25		
	Sta	te	31. Date filed (Month, Day, Year)	32. R strai	r's Signature	1.11			NET	3 18/12	1-0		
	Registr		MAR 2	2006	1 1 h	ALCON DE							

		4	For State Registrar	State of M	laryland		artment of F		and Me		iene	6	08359					
F	Physici	R)-	1. Decedent's Name (First, Middle, Patricia E.	Smith						Month	Day	Year	3. Time of Death					
-	/Medic	al	4a. Facility Name (If not institution,		r)		4b. City, Town, o	or Location of		March :	1		8:40 PM					
	Southern Maryland Hospital Clinto								24 Hrs. 8	D (D)-4.	Princ	4c. County of Death Prince Georges						
	Funeral Director		5. Social Security Number 579–72–5420–A	.Sex X M 2□F	ige (In yrs. Ia 51	rst birthday) Yrs.	Months Days	Hours		Date of Birth (Month, Day, Uly 11	Year) 1954	Cou	place (State or Foreign ntry) ington, DC					
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation						10d. Inside City Limits					
	Maryli a-f sho	tor	MD Prince	Georges	Capi	tol H	eights						1 ∏Yes 2 ☐ No					
	h with the	Funeral Director	10e. Street and Number 4202 Alton Str	eet			10f. Zip Code 20743			1	og. Citizen of Y United							
980	d within 72 hours after deeth with the Maryland jene. Ir than "naturel", or Items 23s or 28s-f show the Medical Evantrar must be notified at	þ	11. Marital Status 1 ☐ Never Married 2[X]Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Forces 1 1 Yes 2 If Yes, Give Year or Dates	;?] No		Was Decedent of the lift Yes, specify Cub			fy Yes or No- can, etc.)	Blac	e - Ameri ck, White, : B1	_					
21215-0036	within 72 hound. Then "neture" Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Customer Service Representative									d of Business/Industry Metro						
and 5	es 1 and 2 should be filed wolf Health and Mental Hygier I Item 27 ie marked othar tir other traumatic avent, in	To Be Co	12th 17. Father's Name (First, Middle, La James Paul Gor	don	18. Mother's Nan Elane H						Maiden Suman	ne)						
Maryland			19a. Informant's Name/Relationshi Melvin L, Smit				ng Address (Stree 2 Alton S											
Baltimore,	Pages 1 a nent of Hea int: If Item iry or othe	1	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	☐Removal from Stat	20b. PI	ace of Dispo	osition (Name of matery or other pla WEMOTIA	(ce)	Da		20c. Location							
Itim			4 ☐Donation 5 ☐ Other (Special Service Li	cify)		rk Ce	metery		3/21			er,	Maryland					
Ba	permit. Depertr Imports any inju	21. Signature on Funeral Service Licenses 22. Name and Address of Facility Austin Royster Funeral Home 3821 14th Street NW Washington, DC 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heary failure. List only one cause on each line.																
	Physician		23a. Part 1. Enter the disease, or c shock, or hear railure. List of Immediate Cause (Final disease or condition resulting in death)	omplications that caus by one cause on each a	ed the death line.	Do not en	rer the mode of dy	ing, such as	cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death					
	/Medical Examiner		resulting in death)		as a consequ	ence of):												
3760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the ettending physicien and rall director, page 2 should be detached for use as the burial-transit	ical Examiner	Examin	Examin	Examin	Examin	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequ	·							
39	rtificate ng phys		IF FEMALE:	d.														
O. Box	that the death certifical led by the ettending phy detached for use as th	Physician/Med	ysician/i	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal at time of de	death 3[⊒Ectopic pregnand □ Other (s <i>pecify</i>) _	Э				te of deliventh	very Day Year				
rds, P.O	quires that in signed by	þ		METASTA	1585		underlying cause g	ven in Part	l.		bacco use con es 2 ☐ No		the cause of death?					
Records,	The law requiete has been page 2 should	Completed	LUNG	ME TASTASES						24a. Was an autopsy autopsy performed? 1 \(\rightarrow s \) 24b. Were autopsy findings prior to completion of cidents? 1 \(\rightarrow s \) 24b. Were autopsy findings prior to completion of cidents? 1 \(\rightarrow s \) 24b. Were autopsy findings prior to completion of cidents.			copsy findings available ompletion of cause of					
Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			_ 0	thor		(Check only or	-							
of	g Phys er this eral dir	n: To	1 ☐ Yes 2X No 27. Manner of _eath	28a. Date of la (Month, I		28b. Time	III JUDON	4014		g Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred								
Division	Attending I ir death. ector: After by the funer	catlo	1 Natural 5 ☐ Pending 2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	ation	M 1 Yes 2 No						28f. Location (Street and Number or Rural Route Number,							
Divi	Il or Attendi after death I Director: A d in by the f	Certification:	4 Homicide determin	286. Place of	etc. (Specify	me, tarm, si	treet, factory, office	•	20	City or Tow		geror Hui	rai Houle Number,					
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C		Physician: To the be xaniner: On the basis and manner	of examinat													
	To th withir To th comp	Me	29b. Signature and title of certified	4.0			29c. Licer	se number	er	2	29d. Date signe	d (Month	, Day, Year)					
	/		30. Name and address of person	completed cause of	of death (Item	23a) (Type	, Print)	7 38	0.5	2 - 0	5/16	(De	0.00					
	2		JENNY 7 . S (31. Date filed (Month, Day, Year)	Utmanon	/5	015	vara175	(COD)	0 #	507 4	n N CON	, ,,,	w+55					
	St Regist	ate rar	MAR 2 0 2	006 032. Regi	J. J.	400												

		1	For State Registrar	State of Ma	ryland /		rtmen tificate					Reg. No.	06	10 10	360	
	Physicia /Medic Examin	al -	Deborah M Deborah M Aa. Facility Name (If not institution, given to the property of the property	. Smith					Location of	M f Death	Da1			Year 2006 4:40a M nty of Death Limore		
	Funeral Director		5. Social Security Number 6. S		(In yrs. last b	oirthday) Yrs.	If Under Months		If Under 2 Hours	24 Hrs.	8. Date of Bir (Month, Da Oct. 29	, 196	9. 1 NC	Birthplace Country DI LII	(State or Foreign Carolin	
	e Maryland la-f show		10a. State 10b. County MD Baltim	i	le River								Inside City Limits 1 ☐ Yes 2 ☐ No			
	with th	Dire	10e. Street and Number 7519 Cleanlake	Lane			10f. Zip	Code 220				10g. Citize	en of What	Country?		
980	be filed within 72 hours after death with the Maryland stal Hygiene. bd other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at event,	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes ② ☑ No ff Yes, Give Year or Dates:				Vas Deced Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto P	orfy Yes or No lican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White				
21215-0036	- 3	Completed	(Specify only highest grade completed) (Gin					edent's Usual Occupation e kind of work done during most of working DO NDT use retired) emaker					own home			
Maryland	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Manaumatic event.	To Be C	17. Father's Name (First, Middle, Last, Charles E. Mc	Clellan					Rosemar			ry Stedding				
Mar	nd 2 she Ith and 27 is m traum		19a. Informant's Name/Relationship (Stephen P. Sm				-				Route Numb					
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other traumatic page.		20a. Method of Disposition XX Burial 2 Cremation 3 C 4 Donation 5 Other (Special	Removal from State	20b. Place	of Dispo	sition (Nan	ne of ther place	9)	D	23/06	20c. Loc	ation - City	or Town,	State	
Balti	permit. Pag Department Important: I any injury o		21. Signa are of Funeral Service Lice	Conne	lly	C	onne	11y		eral	0 Mac Home	of		x 21	1221	
Sep.	Physician		23a. Part1. Enter the disease, or enter shock, or heart failure. List only fmmediate Cause (Final disease or condition		the death. Do e. CARU i			of dying		cardiac oi	respiratory a	rrest,		Inte	proximate erval Between iset and Death Clays	
ids:	/Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Ref	ial	Feri									days days	
,092	ate be executed nysician and he burial-transit	resulting in death) Last Due to (or as a consequence of): d.														
O. Box 68	The law requires that the death certificate be exite has been signed by the attending physician bage 2 should be detached for use as the buria	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1							23d. Date of deliv Month			y Year		
rds, P.O.	quires that t n signed by uld be detai	by	Part II. Other significant conditions	contributing to death bu	it not resulting	g in the u	nderlying d	ause give	en in Part I.						ause of death?	
Records,	The law require ate has been si page 2 should b	Completed			a						Was an ultopsy finding prior to completion of death? as 2 № 0 1 Yes 2 No					
Vital	Physician: rthis certifica ral director, I	Be	25. Was case referred to medical examiner?	Hospital:				. Oth		26. Place of Death (Check only one)						
of	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	ation: To	1 Yes 2 No 27 Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of fnjun (Month, Day	Outpatier Time of Injury						Residence 6 Other (Specify) scribe how injury occurred					
Division	tal or Atta	Certification:	3 Suicide 6 Could not to determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				281. Location (Street and Number or City or Town, State)					or Rural Ro	oute Number,		
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical		hysician: To the best o miner: On the basis of and manner stat	examination.											
	To the within To the comple	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed													
	87		30. Name and address of person who	completed cause of de					21286		KALU	MARC W W		10, 21	00 p	
	Sta Regist		31 Date filed (Month, Day, Year)	a pe	r's Signature		مناه						1 /			

			State of Maryland / Dep	eartment of Health and Martificate of Death	lental Hygie	•	08361
	Dhusis		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medi		June Eileen Sturm		March	15 2006	3:42 A M
	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Gilchrist Hospice 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Towson If Under 1 Year If Under 24 Hrs.	0 D-11 Di-1	Baltimore	
	Funeral Director		5. Social Security Number 296-18-1335 Usual Residence of Decedent 6. Sex 1	Months Days Hours Min.	8. Date of Birth (Month, Day, Y) July 16,	(ear) 9. Birthpla Country 0hio	ce (State or Foreign
	land ow		10a. State 10b. County 10c. City, Town or t	ocation		100	I. Inside City Limits
	Man	ţō	Maryland Howard C	olumbia			1 ☐ Yes 2 ☐ No
	th the	irec	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country	/?
	23 v	al	6845 Sewells Orchard Drive	21045		U.S.A.	
	r dea	Tuel	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Black, White, et	
30	2 hours after death with the Maryland atural; or itema 236 or 28a-f ahow cal Evanting must be redified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No II Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:	•	Specify: Whi	
9500-91212	2 hou	ed	15. Decedent's Education 16a Dec	edent's Usual Occupation	16	b. Kind of Business/Indu	
2 2	within 72 ene. than "nat	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of work DO NOT use retired)	ing	or Dading Ganga	Stry
7	giene giene	ĕ		acher		Educati	on
9	al Hy a oth	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma	iden Sumame)	
<u>X</u>	Ment Ment arke	2	Alfred Kalter		ie Pertlo		
Maryland	in m			ing Address (Street and Number or Rura			
	s 1 and 2 shoul f Health and M ttem 27 is marl other traumati	l i		Sewells Orchard D		umbia, Mary	
وّ	80= 5	1 - 1	I Li Dullai 2 (Li Cremation 3 Li Frentova i Italia 3 tate	ematory`or other place)	-	c. Location - City or Town	
gaitimore,	it. Pa artmen artant: njury			rematory 3-20-	·2006 Ca	atonsville,	Maryland
g	Deperimber on y is		Mr Hackman	Witzke Funeral Hom 5555 Twin Knolls R	es, Inc.		
ı			23a. Part1. Enter the/disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac of	or respiratory arrest	i, A	and 21045 pproximate nterval Between lnset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	1 July 1 M	'S -	- W	eeks
	Examiner		Due to (or as a consequence of):	DOP'N INDE	1	ar.	
		ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	The state of the s	1.1. tello	•	
	s be executed siclen and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		1-1-12		
Ď	be executed iclen and burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):	V (-2)	4.		
2/60	7 2 0	Icai	d				
200	death certifica e attending ph id for use as th	Med	IF FEMALE:				
X O D	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	☐Ectopic pregnancy		23d. Date of delivery Month Da	ay Year
	he de the a	Physician/M	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Monar B	ay rodi
٠ <u>.</u>	thet t ed by detac		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the	cause of death?
SE	The law requires thet the death certifica sie hes been signed by the atlending phage 2 should be detached for use as the	ed by	Fall with Public ramus facture	due to hypoglycemia	1 ☐ Yes	2 No 3 Probab	1
Vital Record	awre is bee 2 sho	plet			24a. Was an	24b. Were autops	y findings available
ř	sicien: The law certificete hes b irector, page 2 s	Completed			autopsy performe 1 Yes 2 1	d? prior to comp death?	letion of cause of No
123	etor, l	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)	XIII	~
> 	hysic his ce	은	1 Nos 2 No Hospital: 1 Inpatient 2 EP/Outpatie	nt 3□ DOA Other: 4□ Nursing Ho	me 5 🗆 Residenc	e 6 Other (Specify)	105010
בֻ ב	ing P	on:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) Injury	of 28c, Injury at Work?	28d. Describe how	injury occurred	
<u>s</u>	tend leath tor: / the fi	cat	Accident investigation March 15 200 UNLINE OF THE STREET			standing	
DIVISION	or At after Dirac in by	Certification;	4 Homicide determined 288. Place of Injury - At nome, farm, si building, etc. (Specify)	.)	City or Town, S		
_	pital ours a eral filled		29a. Certifier Cartifying Physician: To the best of my knowledge, dea				misia mp
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medicai	(Check only one) Additional Examiner: On the basis of examination and/or in and manner stated.	in occurred at the time, date and place, investigation, in my opinion, death occurr	ed at the time, date	se(s) and manner as state and place, and due to the	e cause(s)
	To the To the To the To the To the Somple	Me	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month, Da	y. Year)
	^		Manin	058303	M	orch 15 Zo	06
	1		30. Name and address of person who completed cause of death (tiem 23a) (Type AMON CHALLES, M) 660 (M Charles	Print)	1204		
	Sta	to.			f		
100	Registr		31. Date filed (Month, Day, Year) HAR 2 0 2006				

DHMH 17 Rev 1/2001

at 0342 AM

apirel

STURM

			1 - For State Registrar	State of Maryland /			al Hygien	2006 08	3362
	Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give str	eet and number)	Steve	2. Da	Reg. Nate of Death onth Darch	3. T	Time of Death
	Funeral Director		Usual Residence of Decedent	7. Age (In yrs. last b	Yrs. Months Days	If Under 24 Hrs. 8, Da	ate of Birth fonth, Day, Yea 0 2 1	/ North C	State or Foreign
	th the Marylar or 28a-f ehow e notified at	Director	10a. State 10b. County MD 10e. Street and Number		wn or Location timore 10f. Zip Code		10g. C		side City Limits Yes 2 No
36	be filed within 72 hours after death with the Maryland ital Hyglene. Id other then "natural", or iteme 23e or 28e-f ehow event, the Medical Examiner must be notified at	Funerai	11 W 20th. Street 11. Marital Status	Was Decedent Ever in U.S. Armed Forces? 1	21218 13. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2⊠ No	lispanic Origin? (Specify Y an, Mexican, Puerto Rican, Specify:	es or No-	USA 14. Race - American Ind Black, White, etc. Specify:Black	lian,
21215-0036	I within 72 hour lene. r then "natural" the Wadical Ex	Completed by	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	Year or Dates: ion ompleted) College (1-4or 5+)	a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired Nurse Assist	during most of working d)		Kind of Business/Industry	
73	d a b y	To Be C	17. Father's Name (First, Middle, Last) Unknown 19a. Informant's Name/Relationship (Type	Print) 19	Db. Mailing Address (Street	18. Mother's Name (First	nan	en Sumame)	1
Baltimore, Ma	1 and 2 Health a tem 27 is		Samuel Stevenson 20a. Method of Disposition 1 Burial 2 Cremation 3 Ren	/Son 30	409 Kem Drive of Disposition (Name of ery, crematory or other place Lincoln	Winston Sa	alem, N		
Baltir	permit. Pages Depertment of Important: if ii eny injury or o		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part / Enter the disease, or complica	hall	22. Name and Addre	ss of Facility Marsha St. N.W. Was	all's Fi shington	uneral Home n, D.C. 2001	
	Physician /Medical Examiner		23a. Part / Enter the disease, or complica shot, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence	Dissection		iratory arrest,	Interv	oximate val Between et and Death
68760,	cate be executed obysicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence					
O. Box	at the death certificat by the attending phy tached for use es th	Physician/Med	IF FEMALE: 23c. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	If yes, outcome of pregnancy Live birth 2 Fetal deat Pregnant at time of death Unknown	th 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of delivery Month Day	Year
Hecords, P.	requires tha been signed should be de	Completed by P	Part II. Other significant conditions contri Diabetes mellit Vascular disease	outing to death but not resulting us, hyperto	ension, p	eripheral	3e. Did tobacco		4 Unknown
Vital Re		o Be Comp	25. Was case referred to medical examiner? 1 Yes 2 No Hos	nital·	l Om	1[26. Place of Death Cher	autopsy performed? Yes 2 N ck only one		
Division of	uttending Ph death. ctor: After th y the funeral	Certification; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		Time of Injury M 1	y at k? Yes 2 □ No 28d. D	escribe how in		o Number
ă	Hoepital or 4 hours afte Funeral Dir tely filled in	edical Certi	29a. Certifying Physic	building, etc. (Specify) an: To the best of my knowledges: On the basis of examination a and manner stated.	se death occurred at the tin	Ci	ty or Town, Sta	s) and manner as stated	
ì	To the Hoe within 24 hr. To the Fun completely	Me	29b. Signature and title of certifier	MD, PLD	29c. Licenson			ate signed (Month, Day, Y	
	Sta	ate	30. Name and address of person who comp Victoria Hsiao 31. Date filed (Month, Day, Year)		Ospital 600	Joth Wolfe S	Street, Bo	arch 7,200 altomore, Maryla	ind 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#1, perMD, 0853, 3/20 // 6 TT
State of Maryland / Department of Health and Mental Hygiene Reg. No. UU6 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Robert L. Vaughn, Jr. Month Year 12:45 **Physician** March 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Hospital Johns N/AYear If Under 24 Hrs. B) Date of Birth 9 (Month, Day, Year)
JUNE 24,1971 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 5. Social Security Number Days **Funeral** Months Hours Min. 1 □ M 2 □ F MD. Director 2588 217 06 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in then "neturel", or items 23s or 28s-f show the Medical Examiner must be notified at X Yes 2 No Director BALTIMORE MD. N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21205 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If them 27 is marked other then "naturel", or items 23a eny injury or other traumatic event, the Medical Experiment 2000. 832 N. BOND STREET Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes X2 ☐ No Specify: If Yes, Give Year or Dates: ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) CHEESE CAKE FACTORY College (1-4or 5+) Elementary/Secondary (0-12) COOK 11TH18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EVELYN THOMAS ROBERT L. VAUGHN, SR. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) EVELYN THOMAS GRAY (MOTHER) 5801 WILLOWTON AVE. APT. B 21239 BALTO, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ZION CEMETERY MAR. 21, 2006 BALTO, MD. 21 Anature of Funeral Service Licensee 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME Myly 1412 PRESTON ST. BALTO, MD. E. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebral Intarcts Physician Itiple 20 days /Medical Due to (or as a consequence of): Examiner 20 dau Subarachnoid Hemorrhage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ed by the attending physicien and detached for use as the burial-transit The law requires that the death certificate be executed Enclocargitis Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 V Unknown failure renal 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Abuse 1 ☐ Yes 2 ☐ No hapatitis (Alcohol Abuse, 2 X No Attending Physician: After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28a. Drite of Injury (Month, Day Year) 27. Manner of Dan 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Division 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by within 24 hours after or To the Funerel Direct completely filled in by 4 | Homicide ō i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0062448 March 14,2006 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St VAVAL NESPLAS Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 0 2006 Registrar

John Pages 1 and 2 sho.
Department of Health and important: If tem 27 any injury or 2 **Physician** /Medical Examiner ng physicien and as the burial-transit The law requires that the death certificate be executed attending | o Records, page 2 s of Vital this ieral Diractor: After th Division within 24 hours after death.

To the Funeral Diractor: A completely filled in by the fu 5

Funeral

Director

in than "natural", or Items 23s or 28s-f show the Medical Exeminer must be notified at

la marked other than

ould be Mental

State Registrar

31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and title of certified

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) 32. egistrar's Signature

29c License number

Wysu mo 5710 WARASH BALTIMI) 21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.UU6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Michael Anthony Wright 4:05 AM 2006 16 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St Agnes HOSDITEI altimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 8. Date of Birth (Month, Day, Year) 4 - 3 - 1959 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 1**∑**M 2□ F 212-82-2991 46 Yrs Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Baltimore MD 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2231 Garrison Blvd. Apt. A-1 21216 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. X Never Married 2 Married 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Cook Culinary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vida Hudnall Lee Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2231 Garrison Blvd. Apt. Antwan Johnson A-1 Balto.MD 21231 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🎇 Burial 2 □ Cremation 3 □ Removal from State 3-25-06 Mt. Carmel Dundalk, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wesley Chavis, Jr. FH 21. Signature of Funeral Service Licensee 2007 Eastern Ave. Balto.MD 21231 23a. Pack Effer the disease in complications that alused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Howis ulmonary Due to (or as a consequence of): HTN Year S Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on: Years ESED Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 5 Pending 1 Yes 2 No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

by Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed Be 25. Was case referred to medical examiner? 1 Yes 2 No ٩ 27. Manner of Death Medical Certification: 1-Natural 2 Accident 3 Suicide 4 Homicide 1 Discertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

P1745

900 caton Ano, Baltimore, MD 21229

V

State Registrar

Physician

/Medical

Examiner

Director

Funeral

۵

Be Completed

Funeral

Director

item 27 is marked other than "natural", or itame 23s or 28s-f show other treumstic event, the Madical Examinar must be notified at

the Maryland

filed within 72 hours after deeth

d 2 should be filed within 7 h and Mental Hygiane. 7 is marked other than "n

permit. Pages 1 and 2 sh Depertment of Heelth and Important: If Item 27 is m eny injury or other treum once.

Physician

/Medical

Examiner

use as the burial-transit

signed by the attending physician

ò

be detached

director, page 2 should

certificete

this funeral

Diractor

To the Hospital o within 24 hours of To the Funerel D completely filled in

filled in by

or Attending

death.

W T

I

P.O.

Records.

of Vital

Examiner

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year)

SANJAY

VINJAMARAM 32. Regiştrar's Signature

prosanj

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Seen & food

			For State Registrar	State of Maryland	/ Department of Hea Certificate of De		al Hygiene Reg. No		8366
	nysicia		1. Decedent's Name (First, Middle, Las	1 -	d	М	ate of Death onth Da	y Year	3. Time of Death
Ex Fur	Medica camine neral ector	er	5. Social Security Number 6. Se 2/6-24-5252	RSING Home	st birthday) If Under 1 Year If U	ation of Death TMORE Junder 24 Hrs. 8, Da		County of Death	IMORE place (State or Foreign TH CAROLINA
B Maryland	tifled at		Usual Residence of Decedent 10a. State 10b. County 1ALYLAND N	10c. City,	Town or Location BAL1	TIMORE			0d. Inside City Limits
5-0036 72 hours after death with the Maryland naturel: or Items 23e or 28e-f show	edical Exertiner; ust be notified at	by Funeral Director	10e. Street and Number 8 20 5 , CA 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1	10f. Zip Code 13. Was Decedent of Hispar If Yes, specify Cuban, M 1 □ Yes 2 ☒ No Sp	1229 nic Origin? (Specify Yexican, Puerto Rican		14. Race - Americ Black, White,	an Indian,
_ = *	Medical Ex	Completed b	3 Nation 4 □ Divorced 15. Decedent's Ed (Specify only highest grave) Elementary/Secondary (0-12)	Year or Dates: ucation de completed) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	g most of working	16b. K	ind of Business/In	
M be will year	ic event, the	To Be Cor	3 RP GRADE 17. Father's Name (First, Middle, Last) THO MAS	ÂΛ	HOMEMAK 18.	ER Mother's Name (Firs	t, Middle, Maider		ONE
ore, No	r other tr	13	19a. Informant's Name/Relationship (7 CONSTANCE WALKE 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Type, Print) R DAUGHTER 20b. Pla Removal from State	19b. Mailing Address (Street and In 4122 POTTE ce of Disposition (Name of netery, crematory or other place)	R ST., AFT	101 BA	ocation - City or To	2/229 own, State
Baltin permit. P Departme	any injury o		21. Signature of Funeral Service Licen	W. William	22. Name and Address of	FULTON,	NOR. AVE, B	FUNERA	HOME D. 21217 Approximate
60, be executed be executed by	the burial-transit	dical Examiner	23a. Part1. Enter the disease, or companies, or heart failure. List only of the second	b. Due to (or as a conseque Due to (or as a conseque Due to (or as a conseque C. Due to (or as a conseque d.	Non -ischer		grown of	southy	Interval Between Onset and Death
Box 6	shed for use as	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnand 1 Live birth 2 Fetal of 4 Pregnant at time of dead 9 Unknown	leath 3 Ectopic pregnancy			23d. Date of delive	ery Day Year
rds, P.O.	should be detached	ed by Ph	Part II. Other significant conditions o	ontributing to death but not result	ing in the underlying cause given in	Part I.	23e. Did tobacco		he cause of death?
The law requ	age 2	Completed					24a. Was an autopsy performed?	prior to co death?	opsy findings available impletion of cause of 2 No
of Vital Physician: 1	ector,	Be	25. Was case referred to medical examiner?	Hospital:		. Place of Death (Che			
n of ng Phys	neral di	atlon; To	1 ☐ Yes 2 2 No 27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	P/Outpatient 3 DOA 28b. Time of Injury M 28c. Injury at Work? M 1 Yes		5 ∐ Residence Describe how inju		(y)
Division To the Hospital or Attendi within 24 hours after death.	ed in by th	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, street, factory, office		ocation (Street a City or Town, State	nd Number or Rura e)	al Route Number,
Div	oletely fill	Medical	29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the best of my know niner: On the basis of examination and manner stated.	ledge, death occurred at the time, don and/or investigation, in my opinio	late and place, and d on, death occurred at	the time, date an	d place, and due to	o the cause(s)
To the within 2	com	Σ	29b. Signature and title of certifier	7	29c. License nui	mber 27<72		ate signed (Month,	
4	4		30. Name and address of person who	completed cause of death (Item	23a) (Type, Print) 25 Mam St	Reidon	stown		21136
R	Sta legistr		31. Date filed (Month, Day, Year)	A. Registrar's Signatu		I a complete	-1		

			1 - For State Registrar	State of Marylar		artmer			d Ment		ene		08367
4	Physici	an	Decedent's Name (First, Middle, La Viola P. Willia						٨	ate of Death	Day	Year	3. Time of Death
	/Medio		4a. Facility Name (If not institution, giv			4b. City,	Town, or	Location of D		arch_	9, 200	JO ty of Death	3:15PM [™]
	Funeral Director	ejil.	Rita S Adult Ho 5. Social Security Number 6. S 578–34–7515	OME 7. Age (In yrs.	last birthday) 78 Yrs.		1 Year	Heigh	nts Hrs. 8. D	ate of Birth Month, Day BC , 12	Princ ,1927	9. Birth Was	orges place (State or Foreign inty) nington, DC
	Maryland a-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prin		ty, Town or Lo		ghts						10d. Inside City Limits Yes 2 □ No
	th with the 23s or 28	Funeral Director	10e, Street and Number 5607 Jefferson He	eights Drive		10f. Zij 20	Code 0743			10	og. Citizen o Unite	f What Cou ed Sta	•
980	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or lieme 23a or 28a-f ehow event, Ire Medical Examinar must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Dece If Yes, spe 1 Yes	cify Cubai	spanic Origin n, Mexican, P Specify:	? (Specify Puerto Ricar	Yes or No- n, etc.)		ack, White	
21215-0036	I within 72 ho iene. r than "natur It e Medical.	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		16a. Dece (Give life. Cash	kind of wo	rk done d	uring most of	f working	1	6b. Kind of	Business/li	ndustry
Q	should be filed within a Mental Hygiene. marked other than matic event, the M	To Be C	17. Father's Name (First, Middle, Last Sedwrick Pears					18. Mother's Mage	Name (Firs		laiden Suma	ame)	
, Mar	and 2 sho valth and 1 27 ie mu er trauma		19a. Informant's Name/Relationship (Diane B. William			3	•	ond Number of		ute Number, Shin			
Baltimore,	Pages 1.		20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specia	Removal from State	Place of Dispo cemetery, crei Rock Cr	matory or i	other place	ery 3	Date $3/17/0$		oc. Location Washin		
Balti	permit. Pages 1 and 2 should be Department of Health and Mental important: if Item 27 ie marked any injury or other traumatic ev gnce.		21. Signature of Funeral Service Lice	nsee	A A	2. Name a UStir	nd Addres	s of Facility Ster F Street	unera	1 Home	e	באלו ט()O11
100	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the dea one cause on each line. Metastic F a. Due to (or as a conse	indomet:	ter the mo	de of dying	g, such as car	rdiac or res	piratory arre	st,	100-20	Approximate Interval Between Onset and Death
	Examiner pu	Examiner	fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	quence of):								
, 09289	cate be executed physician and the burial-transit	icai	resulting in death) Last	Due to (or as a conse	quence of):								
O. Box	that the death certificat ed by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	⊒Ectopic p ⊒ Other (s						Date of deli-	very Day Year
Δ.	quires that n signed b uld be deta	þ	Part II. Other significant conditions	contributing to death but not re	sulting in the u	Inderlying	cause give	en in Part I.					the cause of death?
Vital Records,	: The law requires that the cate has been signed by th page 2 should be detache	Completed							-	24a. Was an autopsy perform 1 Yes 2	/	D. Were aut prior to c death? 1 \(\text{Yes}	opsy findings available ompletion of cause of
Vit.	Physician: this certific ral director,	o Be	25. Was case referred to medicat examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpatient 2	TER/Outpation	nt 3 🗆 D	Othe	26. Place of		eck only one 5 ☐ Reside		ASSI	sting Livin
of	ng flein ane	 -	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o		28c. Injury Work	7 🗆 110131	28d.	Describe ho			ny)
Division	To the Hospital or Atlandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	building, etc. (Spec	ity)					City or Town	, State)		ral Route Number,
	he Hosp in 24 hou he Funer pletely fil	edicai	29a. Certifier 1 X Certifying Pl (Check only 2 ☐ Medical Exe one)	hysician: To the best of my kr miner: On the basis of examin and manner stated.	owledge, deat ation and/or in	rvestigation	n, in my op	oinion, death	place, and o occurred at	the time, da	ite and place	e, and due	to the cause(s)
	with To1	W	29b. Signature and title of certifier	act	HYSCIA	a	c. License			29	Marc Marc		. Day, Year) 2006
			30. Name and address person who William J. Cri	ttenden, M.D.	7350 V	an Du	sen 1	Road #	350 L	aurel,	MD 2	0707	
- 6	Sta Regist		31. Date filed (Month, Day, Year) MAR 2 0 200	32. Registrar's Stor	ature								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) Dev Yeer 12:10 AM **Physician** Helen Wells March 18. 2006 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 717 Holly Ave. Pasadena Anne Arundel If Under 1 Year | ff Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthpface (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🖫 F 212-42-7193 60 11/27/1945 Florida Director Usual Residence of Decedent 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 123a or 28a-f ehovust be notified at 1 ☐ Yes 2 ☑ No MD Baltimore Kingsville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7011 Ruxford Road 21087 USA death by Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours atter ment of Health and Mental Hygiene. The stream 27 is marked other then "natural; or ite ury or other traumatic event, the Madical Examins 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Program Manager U.S. Government 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Thomas M. Wood Mary L. Bowersox 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jon Wells Husband 7011 Ruxford Rd., Kingsville, MD21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If its any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 03/20/2006 Catonsville MD * 4 □ Donation 21. Signature of Feral Service Licensee 22. Name and Address of Facility Try L. Kautiman Funeral Home at Meadowridge Memorial Park, IV permit. M01378 7250 Washington Blvd., Elkridge, MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) NAMBIN Physician /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a sunsequence of) Examine or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Box 68760, physician Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregna 1☐Live birth 3 Ectopic pregnancy Month Day Year in the past 12 mon 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed by 23e. Did tobacco use conjunt ute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 3 Probably 4 Unknown 1 Tes 2 PNo cate has been sig. page 2 should b Be Completed Ab. Were autopsy findings a aliable prior to completion of cause of death?

1 Yes No 24a. Was an autopsy perform certificate 1 Yes 2 1 No 25. Was case referred to medicat 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Tother (Special ters House Hospitaf: 2 ER/Outpatient 3 DOA 2 1 🗌 Yes 1 🗌 Inpatient 27. Man of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Aftert 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident s atter death the 6 ☐ Could n of dete med 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) tilled in by 4 Homicide within 24 hours a To the Funeral C Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date figned (Month Day, Year) 29b. Signatu 0 leted cause of death (Item 23a) (Type, Print) 10 31. Date filed (Month, Day, Year) State MAR 2 0 2006 Registrar

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment o		Mental Hy	giene () (06	08369
	Physici	an	Decedent's Name (First, Middle	, Last)		Wil	10 50	2. Date of De Month	Day	Year	3. Time of Death 22:334
	/Media	cal	Donald 4a. Facility Name (If not institution	give street and number)		4b. City. Tow	n, or Location of Dea	March	4c. Count	2006 of Death	22133
1	Examir	ier	1	opkins Hos	pital			ith			
	Funeral Director		5. Social Security Number 218–36–1064	6. Sex 1X M 2 ☐ F	e (In yrs. last birthday 65 Yrs.) If Under 1 Ye Months Da			rth ay, Year) 31,1940	^{9. Birthp} Coun Maryl	lace (State or Foreign try) and
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation.		-	_	11	0d. Inside City Limits
	Mary -feh	ţō	Maryland Balti	more	Dunda.	lk					1 ☐ Yes 2 📆 No
	th with the 23a or 28	Funeral Director	10e. Street and Number 7801 Penninsula	Expressway	Apt 110	10f. Zip Coo 212			10g. Citizen of USA	What Coun	try?
920	toges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other then "natural", or Items 23a or 28e-f ehow or other traumatic event, the Medical Examinat must be richtlish at or other traumatic event, the Medical Examinat must be richtlish at	<u>م</u>	11. Marital Status 1 □ Never Married 2 □ Marr 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? ied 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	Ever in U.S. 13	Was Decedent If Yes, specify (of Hispanic Origin? (Suban, Mexican, Pue No <i>Specity:</i>	Specify Yes or Norto Rican, etc.)	5 Specif	ce - Americ ck, White, y: Wh:	
21215-0036	within 72 ho ene. then "natur he Medical	Completed	15. Deceden (Specify onfy higher Elementary/Secondary (0-12)	's Education it grade completed) College (1-4or 5	(Giv iife.	DO NOT use re	ne during most of w tired)	orking	16b. Kind of 8		steel
	filed v Hygie other f		10 years 17. Father's Name (First, Middle,	Last)	SU	eelworke		ame (First, Middle	1		DCCCI
<u>lan</u>	nould be Mental narked o	To Be	Walter Wills				France	s Mc Dan	iels		
, Maryland	and 2 sho halth and h n 27 is ma er trauma		19a. Informant's Name/Relations Donald Wills Jr				eet and Number or F Avenue,				
Baltimore,	permit. Pages 1 and 1 Depertment of Health Important: If Item 27 eny Injury or other tr once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (S		20b. Place of Disp cemetery, cre Bayview	ematory or other	place) Mar	ch 20,	20c. Location Baltimo:		
Balti	permit. Pa Depertmen Important: eny Injury:		21. Signature of Funeral Service	Licensee Consul			fuleral lers Poir	Home Of	Dundalk	, P.A	•
*	Physician /Medical Examiner	er	23a. Part1. Enter the disease for shock, or heart failure it states from the shock of the shock	a. Due to (or as	a consequence of):	^		ac or respiratory a	arrest,	1	Approximate Interval Between Onset and Death Co. day 5
68760,	w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):						
P.O. Box 6	I the death certifica by the attending ph ached for use as II	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregna □ Other (specify				ite of delive	ry Day Year
	requires that the leen signed by th hould be detache	ed by P	Part II. Other significant condition	ns contributing to death b	ut not resulting in the	underlying cause	given in Part I.		tobacco use con Yes 2 ☐ No	tribute to th	e cause of death?
al Records,	The lar	Completed						24a. Was auto perf 1 Yes	psy ormed2	prior to cor death?	osy findings available npletion of cause of
Vite	Physician: this certificatal director, p	Be	25. Was case referred to medical examiner?	Hospital: 🍾		-55-01	Other	eath Check only			
on of	g P	ilon: To	1 Yes 2 No 27. Manner of Death Natural 5 Pendir 2 Accident investi			of 28c.	4 □ Nursing njury at Nork? □ □ Yes 2 □ No	Home 5 Res 28d. Describe	how injury occur)
Division of Vital	To the Hospital or Attending within 24 hours effer death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investig 3 Suicide 6 Could 4 Homicide determ	not be	ury - At home, farm, s c. (Specify)				(Street and Numi wn, State)	ber or Rura	l Route Number,
	ne Hospita n 24 hours ne Funera	edical C	29a. Certifier 1 Certifyir (Check only one) 2 Medical	g Physician: To the best Examiner: On the basis of and manner st	f examination and/or i	ith occurred at th	e time, date and place ny opinion, death occ	e, and due to the curred at the time	cause(s) and m date and place,	anner as st and due to	ated. the cause(s)
	To the To the Comp	W	29b. Signature and title of certifie		does 5		ense number		29d. Date signe		,
			1	lockadi, He			es-000		March	101	2006
6	e Y		30. Name and address of person PRIGHT MAKADIA	The Johns	Hopkins +	print)	600 Northy	10 Ife Stree	t,Baltimor	re, Mar	yland, 21287
	Sta Registi		31. Date filed (Month, Day, Year)	0 2006 Page	ar's Signature	hortes					

			1 - State Registrar	State of Marylan	-	irtment of H		d Mental H	ygiene Reg. No.	2006	08370
			Decedent's Name (First, Middle, Last))				2. Date of D	eath		3. Time of Death
	Physici		Ellen N.	Young				Marc	h la	Year 2006	6:50PM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of D			County of Death	
			Sinai Hos	pital of Ba	Himae	. B	altin	nore Ci	+4		
	Funeral		5. Social Security Number 6. Se	7.1. aX1 = 1	,,	If Under 1 Year Months Days	If Under 24 Hours N	Min. 8. Date of B	irth	9. Birth	place (State or Foreign
н	Director		102-20-7333	81	Yrs.			Dec.25	192	4	NY
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
	daryl f sho	ō	MD Baltim			esville					1 ☐ Yes 2√∑ No
	the h	Director	10e. Street and Number	.01.6	LIK	10f. Zip Code			10g Citiz	en of What Cou	
	a or	<u></u>		Court			21208		. og. omi	USA	
	death ms 2;	era	21 Mary Carroll 11. Marital Status	12. Was Decedent Ever in U	.S. 13. V			? (Specify Yes or Nuerto Rican, etc.)	lo- 1	4. Race - Ameri	can Indian,
9	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show mary injury or other traumatic event, the Medical Examinant handling all once.	Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No				uerto Rican, etc.)		Black, White,	, etc.
8	rat', c	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2 No	Specify:			Specify: Wh	nite
5-0	72 h	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	ent's Usual Occup	during most of	working	16b. Kin	d of Business/Ir	ndustry
2	vithin ne. hen'	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retired	1)		A	D.	T
2	lled v tygie ther t		17. Father's Name (First, Middle, Last)	4	E C	litor	19 Mathada	Name (First, Middle			troleum Ins
anc	ntal h	Be	7,27			1		len Umla		oumame)	
Š	hould d Me mark matic	ပ္	John W. Burrows 19a. Informant's Name/Relationship (T)		19h Mailin	a Address (Street		r Rural Route Num		Tour State 7	n Codol
Maryland 21215-0036	ith an		Lawrence G. Young			-		urt, Pike			
ē,	Hea Heam tem		20a. Method of Disposition	20b. F	Place of Dispos	sition (Name of	1	Date		ation - City or T	
Baltimore,	Peges ent of ht: #f		1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State		natory or other place ge Cemet	1	/17/06	Pik	esville	MD
₩	mit. Foortar		21. Signature of Funeral Service Licens			. Name and Addres				terstow	·
ä	Depa Impo any i		Stephen	M. Jonks	cus E	line Fune	ral Ho			wn, MD	
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	ications that caused the deat	h. Do not ente	er the mode of dyin	g, such as car	rdiac or respiratory	arrest,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	Pseudo	mon	21 nna	zumoi	Min			Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq		XI PIK	20(1110)	11100			3 mousing
п	Examiner		Sequentially list condutions	Bronci	riec	tas 15					37 years
-	i d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):						1-3
	and and trans	каш	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uanna af):						
8760,	The law requires that the death certificate be executed te hes been signed by the attending physician and bage 2 should be detached for use as the burial-transit	a E		Due to (or as a conseq	derice or).						
387	phys the	dicai		d							
9 X	certif ding ise at	/Me	IF FEMALE:	3c. If yes, outcome of pregna	ancy				2	3d. Date of deliv	0.00
Вох	atter d for u	clar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3	Ectopic pregnancy Other (specify)			-	Month	Day Year
P.O.	the cay the achec	Physician/Med	9 Unknown	9 Unknown							
o,	s thei	by P	Part II. Other significant conditions con	ntributing to death but not res	ulting in the un	derlying cause give	en in Part I.	23e. Did	tobacco us	e contribute to t	he cause of death?
ğ	en sig	edt	COPD, Ig	A deficier	104			1	Yes 25	(No 3□Prol	bably 4 Dunknown
S	aw re	plet	, -					24a. Wa	s an		opsy findings available
Ě	The lay ate hes page 2	Completed							ormed?	death?	empletion of cause of
ita	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place of	Death (Check only			
<u>></u>	Physic this co	2	1 ☐ Yes 2 No		ER/Outpatient		4 U Nursir	ng Home 5 ☐ Re	sidence 6	Other (Specia	(y)
n	ding P h. After I funera	o	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work		28d. Describe	how injury	occurred	
Sio	Attending Physician: r death. ector: After this certific by the funeral director.	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No				
Division of Vital Record	f or Attendated after death Director:	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	et, factory, office			(Street and own, State)	Number or Run	al Route Number,
_	Hospital or 24 hours after Funeral Dir stely filled in		29a. Certifier 1 Certifying Phys	sician: To the best of my kno	wledge death	accurred at the time	no date and o	lace, and due to th	2 021100(0) 2	and manner as a	vated
	24 h	Medicai	(Check only 2 Medical Exami	ner: On the basis of examina and manner stated.	tion and/or inv	estigation, in my of	pinion, death o	occurred at the time	, date and p	place, and due t	o the cause(s)
	To the Hospital or Attending Physician: The law within 24 bours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Me	29b. Signature and title of certifier			29c. License	e number		29d. Date	signed (Month,	Day, Year)
	9		MILLE	Fun		DA	8 6 62	29%	Ma	rch 13	2006
7	[0 1		30. Name and addless of person who co	ompleted cause of death (Item	n 23a) (Type, I	Print	t	- 1 W	1.100	10111	, 5.00
V			Sidney 1	Jels - Tyun		Sinsi +	luspil	1 of Bo1	time	K	
	Sta Registr		31. Date filed (Month, Day, Year) (MAR 2 0	32. Registrar's Signa	iture	Coast 1	0	3298 1 of B21			
				The state of the s							

Young, Ellen

Examined A Saidy Series (Found of Desires) A Saidy Series (Found of Desires) A Saidy Series (Found of Desires) A Saidy Series (Found of Desires) A Saidy Series (Found of Desires) A Saidy Series (Found of Notice) A Said			1 - For State Registrar	State of M	larylan	•		nt of H te of L		and Me	-	gien Reg. No	11116	a mod	083	
ANTIGINATION ACTIONS EXEMPTION EXEMPTION 1.00 A TO 100	Dhusisi		1. Decedent's Name (First, Middle, Last,)									v Y	ear	3. Time of	Death
## POWER CONTROL OF THE PROPERTY OF THE PROPER			JOHN THOMAS ANTHOM	IΥ											10:30	O A M
Social Short Number 1.5 sec 1.5	Examir	er	4a. Facility Name (If not institution, give	street and number	7)		4b. City	, Town, or	Location of	of Death		40	. County of	Death		
THE PROPERTY OF THE PROPERTY O										04.11						
Usuar Brasilization of Decident 100 Colory			10							Min.	(Month, Da	v. Year)	Coun	(rv)	or Foreig
The second property of the control o	Director					5 113.					MAY 30,	1950	CA	LIFU	RNIA	
Security Security	land ow				10c. Cit	y, Town or Lo	cation							10	Od. Inside C	ity Limits
Security Security	Mary 	ţ	MARYI AND MONTCOMERY		STIV	ED CDDI	JC.								1 🗆 Yes	2 🛚 No
Security Security	1 the	rec			DILV	LK BIKII		ip Code				10g. C	tizen of Wha	t Coun	try?	
Security Security	3a o	Ē	12621 SUMMERWOOD DRIVE					2090	14				II.S.A			
Security Security	deat	ner		12. Was Deceden		.S. 13.	Was Dec			gin? (Spec	ify Yes or No	.	14. Race -	Americ		
Security Security	after or its		1 ☐ Never Married 2 🔀 Married	1 [X]Yes 2 [i, rueito r	iicari, etc./			wnite, e	∍tc.	
Security Security	rai',		3 ☐ Widowed 4 ☐ Divorced	Year or Dates	· VIET	NAM	I LI Tes	2121 NO	<i>ъреспу</i> :				Specify:	WH:	TE.	
Beauty B	72 h natu	etec				(Give	kind of w	ork done o	urina mos	t of workin	a	16b. l	(ind of Busin	ess/Ind	lustry	
The Park State Program		du	Elementary/Secondary (0-12)	-	5+)						-	NAT	IONAL S	ECUR	ITY AGE	ENCY
20. Method of Dioposetion 1 Gloral 2 (Exception of State 1) 20. Method of Dioposetion (Name of Dioposetion) 1 Gloral 2 (Exception of State 1) 2 Gloral 2 (Exception of State 1) 2 Gloral 2 (Exception of State 2)	ygie tr	S		2		OPERAT	IONS I	ECHNOI								
20. Method of Dioposetion 1 Gloral 2 (Exception of State 1) 20. Method of Dioposetion (Name of Dioposetion) 1 Gloral 2 (Exception of State 1) 2 Gloral 2 (Exception of State 1) 2 Gloral 2 (Exception of State 2)	be fill d ot	Be									(First, Middle,	Maidei	n Sumame)			
20. Method of Dioposetion 1 Gloral 2 (Exception of State 1) 20. Method of Dioposetion (Name of Dioposetion) 1 Gloral 2 (Exception of State 1) 2 Gloral 2 (Exception of State 1) 2 Gloral 2 (Exception of State 2)	ould Mer Marke	은														
20. Method of Dioposetion 1 Gloral 2 (Exception of State 1) 20. Method of Dioposetion (Name of Dioposetion) 1 Gloral 2 (Exception of State 1) 2 Gloral 2 (Exception of State 1) 2 Gloral 2 (Exception of State 2)	is m						•								,	
23a. Part. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause from each time. Approximate Interval Between Creater and Beach Control and Enterval Between Creater and Beach Creater and	and leelth			FE	20h 5	The second		140 1000	DRIVE,							
23a. Part. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause from each time. Approximate Interval Between Creater and Beach Control and Enterval Between Creater and Beach Creater and	85 = 50		·	Removal from State	1 -	emetery, crei	natory or	other place	9)	U	ile .	20c. L	ocation - Cit	y or 10	wn, State	
23a. Part. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause from each time. Approximate Interval Between Creater and Beach Control and Enterval Between Creater and Beach Creater and	a gir is b				FO						2006	BREN	TWOOD,	MARY	LAND	
23a. Part. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause from each time. Approximate Interval Between Creater and Beach Control and Enterval Between Creater and Beach Creater and	ermit bepar mpor ny in		21. Signature of Funeral Service Licens	0		22 H]	2. Name a INES-R	and Addres	s of Facilit FUNE	y RAL HO	ME. INC.					
shock or hear failure. List only one cause on each ine* Inmadate Cause (Final Inmadate Cause (Fina	4 40540		Umanaac	Tridell	rg	1.1	L800 N	IEW HAN	IPSHIRE	E AVEN	UE, SILV		PRING,	MARY	LAND 20)904
FFEMALE: 23c. If yes, outcome of pregnancy 10 working to death 2 months? 1 more as 12 more as 12	/Medical Examiner	al Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Lines Underlying Cause (Disease or injury that infiliated events	Due to (or a	s a conseq	uence of):								DI V		
The state of the s	death certifi e ettending d for use as	hysician/Medic	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant : 9 ☐ Unknown	2 ☐ Feta at time of d	l déath 3 [leath 5 [Other (s	specity)					Month		Day	
24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings availar profit completion of cause of death? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1 Yes 2 No 28. Describe how injury occurred 28. Describe how injury occurred 28. Unjury at No 28. Unjury at 28. U	quires then signed and signed and be de	þ	Part II. Dther significant conditions col	ntributing to death	but not res	ulting in the u	nderlying	cause give	n in Part I.							
1 Xinatural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 5 Pending investigatio	The law re ite has be	omplet									autop perfo	rmed?	prio	r to con th?	npletion of a	available ause of
1 Xinatural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 5 Pending investigatio	inn: rtific ctor.	0							26. Place	of Death	(Check only c	ne)				
1 Xinatural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 5 Pending investigatio	nysic nis ce	2		lospital: 1 🗌 Inpat	ient 2 🗆	ER/Outpatien	t 3□ D	Othe Othe	r: 4□Nu	rsing Hom	e 5 🖾 Resid	ience	6 Other	Specify)	
2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. VERGARA-SOARES, M.D., 8200 PROFESSIONAL PLACE, LANDOVER, MARYLAND 20785 31. Date filled (Month, Day, Year) 32 Jegistrar's Signature	ter if			28a. Date of Inj	jury ay Year)			28c. Injury Work	at ?	2	3d. Describe I	now inju	ry occurred			
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print) C. VERGARA-SOARES, M.D., 8200 PROFESSIONAL PLACE, LANDOVER, MARYLAND 20785 31. Date filled (Month, Day, Year) 32 Jegistrar's Signature	ath.	atic	2 ☐ Accident investigation	(, -		,2,				No						
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print) C. VERGARA-SOARES, M.D., 8200 PROFESSIONAL PLACE, LANDOVER, MARYLAND 20785 31. Date filled (Month, Day, Year) 32 Jegistrar's Signature	tal or Attu	Certific	datamiaad	28e. Place of In building, 6	njury - At ho etc. (Specif	ome, farm, str y)	eet, facto	ry, office		2				or Rurai	Route Nun	iber,
D16619 MARCH 1, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. VERGARA-SOARES, M.D., 8200 PROFESSIONAL PLACE, LANDOVER, MARYLAND 20785 State 31. Date filed (Month, Day, Year) 32 flegistrar's Signature	he Hospi in 24 hour he Funer pletely filb	edicai	(Check only 2 Medical Exami	ner: On the basis	of examina	wledge, death tion and/or in	occurre vestigatio	d at the tim in, in my op	e, date an inion, dea	d place, at th occurre	nd due to the d at the time,	cause(s date an	and manne d place, and	er as sta due to	ated. the cause(s	s)
D16619 MARCH 1, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. VERGARA-SOARES, M.D., 8200 PROFESSIONAL PLACE, LANDOVER, MARYLAND 20785 State 31. Date filed (Month, Day, Year) 32 flegistrar's Signature	To the To the Comp	Σ	29b. Signature and title of certifier	7	1		29	9c. License	number			29d. Da	ate signed (A	Aonth, L	Day, Year)	
C. VERGARA-SOARES, M.D., 8200 PROFESSIONAL PLACE, LANDOVER, MARYLAND 20785 State 31. Date filed (Month, Day, Year) 32 Pegistrar's Signature	i/		· engans	early	no			D16619)			MAR	CH 1, 2	006		
State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	11		30. Name and address of person who co	ompleted cause of	death (Iten	n 23a) (Type,	Print)									
State 31. Date filed (Month, Day, Year) 32 Registrar's Signature			C. VERGARA-SOARES, I	M.D., 8200	PROFES	SIONAL	PLACE.	, LANDO	OVER,	MARYLA	ND 20785					
Registrar MAR 0.6 2006 American	Sta	te		100			and I	,								

			i icuse i	State of Marylan		artment of			_	_	Jic.	
			1 - For State Registrar	,		rtificate of				No. 0 0	6 0	8372
			1. Decedent's Name (First, Middle, Last))			-	2. Dat	te of Death	Day	Year 3.	. Time of Death
	Physici /Medio		LUCY INSLEY ALDER	MAN						28, 2	006	1:15 a ^M
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town,		f Death		4c. County o		
_			Crofton Convalesc 5. Social Security Number 6. Sec		last birthdav)	Crofton		24 Hrs. 8. Dat	te of Birth		Arunde 9. Birthplace	
	Funeral Director			M 2⊠F 84	Yrs.	Months Days	Hours	Min. Nov	te of Birth onth, Day, Y	1921	Virgin:	(State or Foreign ia
	الم الم		Usual Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Lo	ecation					10d I	Inside City Limits
	Aaryla f shor	ō	Maryland Anne Aru		fton	7041011						1 XYes 2 No
	28e-	Director	10e. Street and Number	inder ore	TLOII	10f. Zip Code			10g	. Citizen of W	/hat Country?	
	h with	al Di	21412 Davidsonvil	le Road		2111	L 4		U	S.A.		
	ems ems	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Orig ban, Mexican,	in? (Specify Ye Puerto Rican,		14. Race	- American Ir	ndian,
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 ∐Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2 💆 No	Specify:			Specify:	White	į
9	filed within 72 hours after death with the Maryland Hygiene. ither then "naturel", or ttems 23a or 28e-f show ant, the Madical Exemitment and the motified at	ted t	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occu	pation		16	b. Kind of Bus	siness/Industr	у
215	thin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	e com <i>pleted)</i> College (1-4or 5+)	(Give	kind of work done DO NOT use retir	ed) most	of working				
7	led wi	Con	17. Father's Name (First, Middle, Last)		Admi	tting Cl		r's Name <i>(First</i> ,				s Hospital
anc	d be fi	Be c	Fitzhugh L. Insle	v Sr.				Widgeo		iden Sumame	9/	
Maryland 21215-0036	shoul nd Me mark	우	19a. Informant's Name/Relationship (Ty		19b. Mailir	ng Address (Stree				City or Town, S	State, Zip Coo	
	and 2 alth a 127 is er tre		Lucy Dobson - Dau	ghter	1220	3 Mackel	ll Lane	, Bowie	, Mar	yland	20715	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other then "naturet", or Items 23a or 28e-f show any njury or other treumatic event, the Madical Exercitive Items to the Intiffied at once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F	20b. F	Place of Dispo semetery, crer	sition (Name of matory or other pl	ace)	Date	20	c. Location - 0	City or Town,	State
Ē	thent of I		`4 □ Donation 5 □ Other (Specify)	Par	klawn (Cemetery 2. Name and Add	<u> </u>	3/3/200	6 Ro	ckvill		
Ba	Department of the poor of the		21. Signature of Funetal Service Lights	MA1312		739 Balt					-	
	_		23a. Part1. Enter the disease, or compl	ications that caused the deat								proximate erval Between
b.	Pnysician		shock, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each ime. _{a.} Hypertensive	Cardi	03726011	r Dico	200			Ons	set and Death
	/Medical		resulting in death)	Due to (or as a conseq		ovascula	II DISC	ase			1e.	ars
	Examiner	L	Sequentially list conditions, if any, leading to immediate	Dementia		12 - 12		=			Ye	WES .
	ted	nine	Cause (Disease or injury	Due to (or as a conseq	uence or):						Mo	eks
Ć	execu in and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):						We	CKS
3760	death certificate be executed e attending physician and of for use as the burial-transit	icai		d								
39 xo	entifica ding ph	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregna	and a							-
Bo	leath certific attending p	cian	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3	Ectopic pregnant Other (specify)	су			23d. Date Mon	of delivery th Day	Year
Ö.		hysi	1 □ Yes 2 ፟ No 9 □ Unknown	9□ Unknown								
s, D	The law requires that the de Ite has been signed by the a bage 2 should be detached f	by P	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	nderlying cause g	iven in Part I.	23				ause of death?
ord	w requir been si should	eted							1 ∐ Yes			4 □Unknown
Record	e taw has b je 2 sl	Completed						24	a. Was an autopsy	l pr	lere autopsy f rior to complete eath?	findings available ition of cause of
	n: Th ificate or, pag		25. Was case referred to medical				OC Place		yes 2	No 11	☐Yes 2☐	No
\equiv	Physicien: this certificaral director, I	o Be	evaminer?	Hospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA	thon	of Death (Chec rsing Home 5		e 6 □Othe	or (Specify)	
Division of Vital	tending Physicien: The leath. tor: After this certificate ha the funeral director, page	n: T	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Inju	ury at ork?	28d. De	scribe how	injury occurre	ed	
<u>S</u>	Attending It death. ector: After by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	DO - Diana of laines At h]Yes 2□N		astina /Ctm	at a med Altimation		uto Mumbas
\leq	in Dir	Certification:	4 Homicide determined	28e. Płace of Injury - At he building, etc. (Specif	y)	өөт, тастогу, опісе	•		y or Town, S	et and Numbe State)	or Hurai Hoi	yle ivumber,
	the Hospitel or hin 24 hours after the Funeret Dir mpletely filled in		29a. Certifier 1 X Certifying Phy (Check only 2 Medical Exami	sician: To the best of my kno	wledge, deati	h occurred at the	time, date and	place, and due	to the caus	se(s) and man	ner as stated	 l.
		fedical	one)	ner: On the basis of examina and manner stated.	.tion and/or in			n occurred at th				
	To the within to the comple	Σ	29b. Signature and title of certifier	1001000	V		20	08	290.	Date signed	O G	rear)
•	H		30. Name and address of person who co	ompleted cause of death (Item	1 23a) (Type					~ 1, 1		
le e	20		Rakesh Arora, MD	14300 Gallan		•	wie, M	aryland	2071	5		
	Sta		31. Date filed (Month, Day, Year) MAR 0 3	32. Registrar's Signa	iture							
	Registr	ar	might 4.9	2008 Charles	- A	down						

		·	For State Registrar	State of Maryla		artment of H rtificate of L		F	Reg. No. U U	5 08373
	Physici /Medio		Decedent's Name (First, Middle, Last	st) McArthur Bari	nard			2. Date of Dea Month March	10 ^{Day} 200	3. Time of Death 1455 P M
P	Examir		4a. Fecility Name (If not institution, give Sunbridge Health			4b. City, Town, or Elkton		1	4c. County of	
8	Funeral Director		5. Social Security Number 6. S		s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day May 18,	7 Year) 1942	9. Birthplace (State or Foreign Country) Virginia
	Aaryland I show	or	Usual Residence of Decedent 10a. State 10b. County Delaware New Ca		ity, Town or Lo		•			10d. Inside City Limits 1 □ Yes 2 ☑ No
	or 28e-	Director	Delaware New Ca	stie 1	New Cas	10f. Zip Code			10g. Citizen of W	hat Country?
36	172 hours after death with the Maryland "natural", or Iteme 23e or 28e-1 show safeal Examiner must be mortified at	by Funeral	8 Parma Avenue 11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates:		19720 Was Decedent of Hi If Yes, specify Cubar 1 □ Yes 2\textbf{N} No		pecify Yes or No- o Rican, etc.)		d States - American Indian, t, White, etc. Black
Maryland 21215-0036	d within piene.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done d DO NOT use retired, uck Drive	luring most of wor	king	16b. Kind of Bus	
yland 2	be filed Ital Hyg od othe event,	To Be C	17. Father's Name (First, Middle, Last) Emmitt Barnard				18. Mother's Nam Mae Hi	ne (First, Middle, unter	Maiden Sumame	»)
	12 sh h and 7 Is m treum		19a. Informant's Name/Relationship (Marie Barnard/S			ng Address <i>(Street a</i> Friend <i>s</i> hi			-	State, Zip Code)
Baltimore,	Pages 1 and 2 ment of Health ent: If item 27 I ury or other tre		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	20b.	Place of Dispo cemetery, crei	sition (Name of matory or other place morial Pa:	⁹⁾ Mare rk 200	ch 16,	20c. Location · C	city or Town, State
Balt	permit. Pag Depertment Importent: any injury c once.		21. Signature of Funeral Service Licer	Dieke	H H 1	Name and Addressicks Home 03 W. Sto	s of Facility for Fun ckton St	erals, P	on, MD	21921
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line	ath. Do not ent					Approximate Interval Between Onset and Death Unknown Unknown
V	ransit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a conse						www
8760,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a conse	equence of):					
.O. Box 6	death certifi e attending od for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of preging 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	of delivery th Day Year
rds, P	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions of	contributing to death but not re	esulting in the u	nderlying cause give	n in Part I.	23e. Did to	_	bute to the cause of death? 3 Probably 4 Unknown
of Vital Record	The ete h page	Completed		· · · · · · · · · · · · · · · · · · ·				24a. Was a autop perfor 1 Yes	sy pr med? de	dere autopsy findings available for to completion of cause of eath? Yes 2 No
Vita	Physicien: this certifice al director, p	o Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2[☐ ER/Outpatier	nt 3 DOA Othe	_ /	th <i>(Check</i> on <i>ly or</i> ome 5 ☐ Resid		· (Specific)
	Attending Physic death. ector: After this by the funeral di		27. Manne of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injury Work			ow injury occurre	
Division	Dir	Certification;	3 Suicide 6 Could not be determined	building, etc. (Spec				City or Tow	n, State)	r or Rural Route Number,
	To the Hospitel or within 24 hours after To the Funerel Director completely filled in the Funerel Director of the Funerel Dire	Medical	(Check only 2 Medical Exar	nysician: To the best of my kr niner: On the basis of examir and manner stated.	nowledge, deat nation and/or in	h occurred at the tim vestigation, in my op	e, date and place inion, death occu	, and due to the or rred at the time, o	ause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
)	To the within 2 To the complet	Σ	29b. Signature and titroof certifier	ars md		29c. License	23322		3.10	(Month, Day, Year)
	2		30. Name and address of person who S. S Saelidev	1417 110	om 23a) (Type,	Print)	Chten	MD 21	92/	
	Sta Registi		31. Date filed (Month, Day, Year) MAR 2 0	32. Registrar's Sign	nature	and !				
DH	MH 17 Rev 1/2	001	III, III, III	1000	8					

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)
MAR 2 0 2

. Registrar's Signature

blien & special

State of Maryland / Department of Health and Mental Hygiene UU 5

			1 = For State Registrar	Otato .	o, maryta			of Deat		ionian i i	Reg. No.	. 4	
100	ak A	Ø.	1. Decedent's Name (First, Middle	, Last)						2. Date of De	eath		3. Time of Death
	Physici /Medio		Charles Lee	Beckwith						Month Februa	Day arv 23	Year 2006	6:24 P M
	Examir		4a. Facility Name (If not institution,				4b. City, To	own, or Locatio	n of Death	10010		ty of Death	0.241
ि			Washington A	dventist	Hospit	:a1		Takoma	Park		ı	Montgo	merv
- SA	Funeral		5. Social Security Number	6. Sex	7. Age (In yr.	s. last birthday)	If Under 1 Months	Year If Und	ler 24 Hrs. s Min.	8. Date of Bi (Month, D	rth		place (State or Foreign
	Director		577-66-2307	1 X M 2□F	5	7 Yrs.					2, 1948		h Carolina
	land		Usual Residence of Decedent 10a, State 10b, County		10c. C	City, Town or Lo	ocation					1	Od. Inside City Limits
	Mary f she	ō.	Mourel and Dud	- 0	,_		77		11				1X Yes 2 No
	28a	Director	Maryland Princ 10e. Street and Number	e George	S		10f. Zip C	vattsvi ode	ıle		10g. Citizen o	f What Cour	ntry?
	3a or		2600 Queen	s Chanel	Rd #	101		207	82			ed St	*
	death ms 2	Funeral	11. Marital Status	12. Was Dec	cedent Ever in		Was Decede	nt of Hispanic (Cuban, Mexic		ecify Yes or No		ace - Americ	an Indian,
Maryland 21215-0036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If Item 27 ie marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2X Marri 3 Widowed 4 Divorced	Armed F ed 1 Yes If Yes, G Year or I	2 X No		If Yes, specif			Rican, etc.)	Spec	ack, White, ify: $ m B1$	_{etc.} .ack
0	72 ho	Completed	15. Decedent		1)	16a. Dece	dent's Usual	Occupation done during m	ant of work		16b. Kind of	Business/Inc	dustry
2	thin 7	nple	(Specify only highes Elementary/Secondary (0-12)	T	(1-4or 5+)	life.	DO NOT use	retired)	OSI OF WORK	ng			
2	ed wi	Co		2			C1	Lerk				civate	}
pu	be fill H d oth	Be	17. Father's Name (First, Middle, L					18. Mo	ther's Name	First, Middle	, Maiden Surna	ime)	
₹	ould Men Merke Larke	은		ey Beckw	ith						ka Maso		
Jar	2 sh and le m		19a. Informant's Name/Relationsh		. c .								Code) 20782
	1 and 1ealti m 27		Gwendolyn Be 20a. Method of Disposition	CKWILII/W.		Place of Dispo		Transaction Transaction		og #IUI	, Hyatt		
Baltimore,	ages nt of the		1 ☐ Burial 2 ☑ Cremation	3 □Removal from	1	cemetery, cre	matory or oth	er place)	1				
Ē	it. Partmer		4 □ Donation 5 □ Other (Sp 21. Signature of Egneral Service L				Crema			/2006		linton	
Ba	Depa Impo any ir		21. Signature of Puneral Service L	Stewar	& III	24		Address of Fac Benni:			Funeral Wash.,		
8			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that	caused the des	ath. Do not ent	ter the mode	of dying, such	as cardiac c	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	R	swing.	Ack	1::	1100	Ci in	7-			Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conse	equence (f):	Teu	1	ci cic	2			
	Examine	_	Sequentially list conditions,	b. <u>Se</u>	vere	anen	ia S	tomo	mic	dia	are		
	9d sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a conse	equence of):		J ~					
	rtificate be executed ng physicien end s as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Me	or as a conse	aduence of):	roch	ale (anc	er			
90	be exicien				(5, 60 6 55.100	5440.100 01/.							
68760,	icate phys s the	Medical		d									
	S G S		IF FEMALE:	23c. If yes, or	utcome of preg	nancy					23d D	ate of delive	20/
Box	The law requires that the death ce sie has been signed by the attendi page 2 should be detached for use	Physician/	in the past 12 months?		birth 2 Fe]Ectopic preg] Other (s <i>pec</i>				1	lonth	Day Year
o.	the c	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unkr				,,					
S, D	s that ned t	by P	Part II. Other significant condition	ns contributing to	death but not re	sulting in the u	nderlying cau	se given in Pai	rt I.	23e. Did	tobacco use co	ntribute to th	ne cause of death?
ğ	w require been sig should b						_			1 🗆	Yes 2 □ No	3 🗌 Prob	ably 4 Unknown
000	taw requas been 2 should	Completed								24a. Was		. Were auto	psy findings available
æ	The lav	E									ormed?	death?	mpletion of cause of 2 No
ital	icien: Th certificete rector, pag	0	25. Was case referred to medical					26. Pla	ice of Death	1 Yes	.44	10 763	20140
>	Physic this ce al direc	To B	examiner? 1 □ Yes 2√2 No	Hospital: 1 [3	inpatient 2	☐ ER/Outpatier	nt 3 DOA	Other: 4	Nursing Ho	me 5 Resi	idence 6 🗆 O	ther (Specify	v)
0	ding PI h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time o Injury	f 280	. Injury at Work?	1	28d. Describe	how injury occu	ırred	
sio	eath. or: A	cati	2 Accident investig	ation			М	1 Tes 2	□No				
Division of Vital Record	t or Attendation after deati	Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 286. Plac	e of Injury - At ding, etc. (Spec	home, farm, str cify)	eet, factory, o	office			Street and Nun wn, State)	iber or Rura	l Route Number,
	ospitel hours unerel ly filled	edical Co	29a. Certifier 1 Certifying	Physician: To the ixaminer: On the l	e best of my kr	nowledge, deat	h occurred at	the time, date	and place, a	and due to the	cause(s) and n	nanner as st	ated.
	To the Hi		One)	and mar	nner stated.	unwor III				-3 at the thire,			
	2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Σ	29b. Signature and title of certifier	mp mp			29c. l	icense numbe			29d. Date sign	1	Day, Year)
	(5)		10 1000				Í	2630	1 > -1		2/24	106.	
	Je		30. Name and address of person v	nho completed cau	11001	0		0 1-	1 4	789 · 4			20212
3	Second State Second		31. Date filed (Month, Day, Year)		Registrar's Sign	nature	7600	carroll	L Ave.	, Tako	ma Park	, MD	20912
	Sta Registr		MAR 0 6 2006	Eleve !	A Chi	rocke							

			1 - For State Registrar		of Marylar	•	artment o					Reg. No.	006	333	17
	Physici	an	Decedent's Name (First, Middle							2	Date of Dea Month	ath Day	Yeer	3. Time of	
100	/Media	al		BERRY,							Feb.		2006	9:30) A ^M
	Examir	er	4a. Facility Name (If not institution		mber)		4b. City, Tov			Death			County of Dea	ith	
		(1) (c)	22 Fairmont P. 5. Social Security Number	Lace 6. Sex	7. Age (In yrs.	last hirthdayl	India:		ad Under 24	4 Hrs. o	. Date of Birt		arles	th=l=== /C+=+==	
	Funeral Director		577-58-0494	1 Q M 2□F	62	Yrs.			lours		(Month, Da)	y, Year)	1_ 0	thplace (State of ountry) 1.,D.C.	r r-oreign
			Usual Residence of Decedent		- 02						12/31/	1940	Wasi	1., 0.0,	
	yland		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside Ci	ty Limits
	Marie Marie	ctor	Maryland Charle	es		In	dian H	ead						1 x XYes	2 No
	ith the	Oire	10e. Street and Number				10f. Zip Co	de				10g. Citiz	en of What Co	ountry?	
	238 238	Funeral Directo	22 Fairmont P.	lace			206					I	ISA		
	r deg	ne I	11. Marital Status	Armed Fo	edent Ever in U proes?	l.S. 13. V	Was Decedent f Yes, specify	ol Hispar Cuban, M	nic Origir lexican, i	n? (Specif Puerto Ric	fy Yes or No- can, etc.)	- 1	 Race - Ame Black, White 		
36	or h	by Fu	1 Never Married 2 Mar 3 Widowed 4 Divorced	If Yes, Gr	ve		∏Yes 2 ∑		pecify:					hite	
21215-0036	hour fural	pg p		Year or D	ates:	162 Dagge	lent's Usual O	acupation				10h Ki-			
<u>.</u>	in 72	Completed	(Specify only highe	st grade completed)		(Give	kind of work d OO NOT use re	one durin	g most o	of working		IBD. KIN	d of Business	rindustry	
72	with ther	E O	Elementary/Secondary (0-12) 9th	College (1-4or 5+)		Mecha					Priz	zate Tr	ndustry	
D	be filed within 72 hours after death with the Maryland Hygiene. d other then "natural", or itema 23a or 28a-f ehow event, the Madical Evantral must be notified at		17. Father's Name (First, Middle,	Last)			1100110		Mother's	s Name (/	First, Middle,			iduser y	
ä	lenta lenta rked	To Be	Henry C. Berry	y, Sr.					Dor	is A.	. Arms	trong	ζ		
ary	shou and M mai		19a. Informant's Name/Relations	, , , , ,		19b. Mailin	g Address (St	reet and	Number	or Rural F	Route Numbe	er, City or	Town, State,	Zip Code)	
Σ	alth a alth a 27 kg		Theodore Green	n/brother	in law	Post	Office	Box	906	Lal	lata,	MA 2	20646		
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of the m 27 is marked other than "natural," or itema 23a or 28a-1 show any injury or other traumatic event, the Maclical Examinar must be notified at once.		20a. Method of Disposition		,	Place of Dispo	sition (Name o	of		Dat			ation - City or	Town, State	
Ĕ	Page nent c int: If		1 Burial 2 Cremation 4 Donation 5 Other (S		State	verdale			athr	v 3/1	1/06	Rive	rdale,	M-I	
<u>=</u>	parin porta y Inju		21. Signature Jun ral Service	Licensee	2122		. Name and A			, ,,	1700	KILVE	ar dare,	20746	
m	99 5 8 9		Mar	-1 N	101453	Се	dar Hi	11 FI	H, Ind	c. 41	l 11 Per	nnA	ve. Su	itland,	
-36	- A		23a. Part 1. Enter the disease, or shock, or heart failure. List											Approximate Interval Bets	е
	Physician		Immediate Cause (Final disease or condition	only one cases on c	C 0 20	inox		18+			dist		0	Onset and [
1	/Medical		resulting in death)	a. Due to	(or as a conseq	juence ol):	9	101		<u> </u>	(X12)	. 013			
	Examiner		Conventially list conditions	h											
ь.	n =	ner	Sequentially list conditions, if any, leading to intriediate cause. Enter Underlying Cause (Disease or injury	Due to	(cr as a conseq	uence of).									
	nd nd trans	Examiner	that initiated events	c											
Ö,	e exe ian a urial-	EX	resulting in death) Last	Due to	(or as a conseq	juence of):									
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and vage 2 should be detached for use as the burial-transit	Physician/Medical		d											
õ	eath certific attending pl	Mec	IF FEMALE:	1											-
Box	ath ce ttend or us	lan/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	tcome of pregna pirth 2 D Feta	ıl death 3 ☐	Ectopic pregn					23	3d. Date of dea		/ear
_ _	the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐ Pregr 9⊡ Unkn	nant at time of d own	leath 5	Other (specif	y)					197011111	Duy !	Jul
P.O.	hat the day detac		Part II. Other significant condition	ons contributing to d	eath but not rec	ulting in the ur	doshina onus	o anon in	Padl		23a Did to	h2000 US	o contributo te	the cause of d	loath?
Ŝ	n requires that the de been signed by the i should be detached	by	Tarin. Ottor digitalogic contains	one continuously to d	04(11)0(110(103	oung in the di	idenying caus	e giveri iii	raiti.			es 2 🗆			Jnknown
0	requ	Completed				-				_					
န္တ	has t	ldu									24a. Was a autop	sy	prior to	utopsy findings a completion of ca	available ause ol
<u></u>											perfor 1 🗆 Yes	2 No	death?	2 □ No	
<u> </u>	ician certifi ector	Be	25. Was case referred to medica examiner?	Hospital:					Place of	f Death /	Check only o	ne)			
ŏ	Phys this aldi	٦.	1 Yes 2 No 27. Manner of Death	28a. Date		ER/Outpatien 28b. Time of			Nursi				Other (Spe	city)	
5	ding I	5	1 Natural 5 Pendir	ig (Mon	th, Day Year)	Injury		Injury at Work?	2 DNa		d. Describe h	low injury	occurred		
Division of Vital Records,	or Attending Physician: after death. Director: After this certifics in by the funeral director,	ica	2 Accident Investi 3 ☐ Surcide 6 ☐ Could	not be 200 Place	ol Injury - At he	ome larm stre			2 🛄 140	281	Location /S	treat and	Number or Pi	ural Route Num	bar
⋛	after Dire	Certification:	4 Homicide determ	buildi	ng, etc. (Specif	(y)	30t, 1 a 0t01 y , 011	1100		-0.	City or Tow	n, State)	740111007 07 710	orar ricote ridini	<i>761</i> ,
	Hospital 24 hours of Funaral tely filled		29a. Certifier 1 Certifyir	ıg Physician: To the	best of my kno	wiedge death	occurred at th	ne time d	late and i	place and	d due to the o	ause(s) a	nd manner as	stated	
	I 4 II 0	edicai		Examiner: On the b	asis of examina ner stated.	ition and/or inv	estigation, in i	my opinio	n, death	occurred	at the time, o	date and p	lace, and due	to the cause(s	,
	To the H within 24 To the Fi complete	Me	29b. Signature and title of certifie	A /	,			cense nur					signed (Mont		
	,			And -	_		D	146	47	8		3-1	-06		
1.	- 4		30. Name and address of person	who completed caus	se of death (Iten	n 23a) (Type.	Print)								
4Y	=		Suresh F	1. Parte	1 mm	750	1 SU	280	115 8	Zel.	clin	ton-	MD	207	35
	Sta		31. Date liled (Month, Day, Year) MAR 0 3 20	06 32. F	egistrar's Signa	ature	. ,					- 9 [
	Registr	ar	MAR V J ZU	NO PROPERTY	-	The same of									

		Please Type or Print in State of Maryl 1- For Registrar	and / Depa		ealth and M	ental Hygie	_	08378
	siciar edica					2. Date of Death Month O Z	Day Year 2 6	3. Time of Death
V 35.7	mine	A C The Name of the Administration of the American Action	CENTER	4b. City, Town, or Chever.	Location of Death 1y, Md.		4c. County of De. P.G.	ath
- Fune Direct	_	5. Social Security Number 577-74-8635 & Sex 37. Age (In)	vrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Feb., 8ay, Y	^{9. B} Wa	rthplace (State or Foreign Country) Sh., DC.
Maryland	į	Md PC	City, Town or Lo Jpper M	cation arlbore				10d. Inside City Limits 11 Yes 2 □ No
h with the	Direct	100. Street and Number 12809 Prince Leigh St.		10f. Zip Code 20774			. Citizen of What C	Country?
15-UU36 172 hours after death with the Maryland 172 hours after death with the Maryland 17-eturef; or fleme 23e or 28a-f ehow	hy Funeral Director			Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2☐No	spanic Origin? (Spe n, Mexican, Puerto I Specity:	cify Yes or No- Rican, etc.)	14. Race - Arr Black, Wh Specify:	
filled within 72 ho Hygiene. other then "neturent, meturent	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Deced (Give life. Mec	tent's Usual Occupa kind of work done d O NOT use retired) ITATILC	tion uring most of workin	ng 16	b. Kind of Busines Automot	I have a
d be sontal	ď	James Edward Belcher			18. Mother's Name Lonie	Bennet	t	
Mar d 2 sh d 2 sh h and h and 7 ts m treum		19a. Informant's Name/Relationship (Type, Print) Sumatra Belcher- wife	128	09 Princ	e Leigh	St. Up	per Mar	Zip Code) 20774 lbore Md.
Baltimore , permit. Pages 1 and Department of Heali important: if item 2 any injury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		Memoria			c. Location - City o andover	
Demit Depart Import	Suc	21. Signature of Fungral Service Licensee	Od!	wasnin	igton, D	.C. 200	01	h St. N.W.
Physicia /Medic Examin	al er	23a. Part1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a condition figure, leading to immediate) Due to (or as a condition figure, leading to immediate)	etuntu	Pulm pn		•		Approximate Interval Between Onset and Death
COIdS, F.O. BOX 08/00, wrequires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-itansit	edical Examiner							
the death certily the attending years attending to the attending to the attending to the a	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of do Month	elivery Day Year
wrequires that the death been signed by the atter should be detached for u	d by	Part II. Other significant continuous contributing to death but not	resulting in the ur	nderlying cause give	n in Part I.		~ 1	to the cause of death? Probably 4 Unknown
The larate has	Comp					24a. Was an autopsy performe 1 Yes 2	d? prior to death?	
ysician: nysician: nis certific	To Be	examiner? 1 Yes 2 No Hospital: 1 X postient 2	P ☐ ER/Outpatien	t 3 DOA Othe	26. Place of Death		e 6 ∐Other (Sp.	ecify)
ding I			28b. Time of Injury	28c. Injury Work' M 1 \(\triangle Y	at 2 ? 'es 2 □ No	8d. Describe how	injury occurred	
	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - A building, etc. (Sp.	t home, farm, streecify)	eet, factory, office	2	28f. Location (Stree City or Town,	et and Number or F State)	Bural Route Number,
Los the Hospitat or within 24 hours after To the Funerei Dir completely filled in	Medical		knowledge, death ination and/or inv	occurred at the time restigation, in my op-	e, date and place, a inion, death occurre	and due to the caused at the time, date	se(s) and manner a a and place, and du	s stated. e to the cause(s)
To To To To To To To To To To To To To T)	29b. Signature and title of certifier A. Muhoel igo	حہ	-	52865	- /		1, 2006
E)	0	30. Name and address of person who completed cause of death (100 / H	Print) USJOITAL	Dr Ci	hever	14 me	20785
	State istrar	31. Date filed (Month, Day, Year) MAR 0 3 2006	gnature fpa	W				

DHMH 17 Rev 1/2001

			1 State Registrar	Otate of the	Maryland / Dep <i>Ce</i>	artment of rtificate of		and Mental F	Reg. No.	06	08	379
Ä	Physic /Medi		Decedent's Name (First, Middle, Last John		roady			2. Date of Month	Death Day	Year 2.006	3. Time	of Death
	Examir		4a. Facility Name (If not institution, give Doctors Communi		•	4b. City, Town, Lanh			4c. Coun	nty of Death		s
	Funeral Director		5. Social Security Number 6. S 577-56-5797 Usual Residence of Decedent	ex X M 2□ F	Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year Months Days		Min. (Month,	Birth Day, Year) ber 3,19		nplace (Stai untry) Virgin	te or Foreign Nia
	e Maryland e-f show	ctor	10a. State 10b. County Maryland Prince	Georges	10c. City, Town or Lo							City Limits
	with the	I Dire	10e. Street and Number 9716 Annapolis	Road		10f. Zip Code	706		10g. Citizen o		•	
9036	be filed within 72 hours after death with the Maryland stal Hygiene. Id other than "natural", or items 23a or 28a-f show event, I're Medical Examinational be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force 1 Yes 2 If Yes, Give Year or Dates	s? [No		Hispanic Ori ban, Mexican	gin? (Specify Yes or , Puerto Rican, etc.)		ace - Amer lack, White	ican Indian	,
21215-0036	d within 72 h giene. er then "natu	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0·12) 12th grade	lucation de completed) College (1-40	r 5+) (Give	dent's Usual Occu kind of work done DO NOT use retire ock Cler	during mosi ed)	of working	16b. Kind of Safewa		,	Store
D	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Ira M.	0	17. Father's Name (First, Middle, Last) James Edward	Broady				r's Name (First, Midd	lle, Maiden Suma	am <i>e)</i>		
aryl	should be f and Mental I s marked of numatic eve	To	19a. Informant's Name/Relationship (fe) 19b. Maili	ng Address (Stree		r or Rural Route Num		n, State, Zi	p Code)	
Baltimore, M	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e-		Jean Elizabeth Ga 20a. Method of Disposition 1 ABurial 2 Cremation 3 Companies 4 Command 5 Other (Specify 21. Signature of Juneral Services)	Removal from State	20b. Place of Dispo cometery, cre Maryland	esition (Name of matory or other pla Nationa Nationa N. Ho	1 Memo	d; Lanham March 2,20 Orial Park Company Mo Treet,N.W.	06 Laure	1 - City or T	own, State	nd
	Physician /Medical Examiner the private and pural-transit sthe private and street str	dical Examiner	23a. Part1. Enter the disease, or come shock, or heart failure. List only find failure and the condition resulting in death) Sequentially list conditions, if any, feating to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a b. Due to (or a c.	ed the death. Do not entline.	er the mode of dy	ing, such as		arrest,		Approxin Interval E Onset ar	nate Between
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Mec	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetaf death 3	Ectopic pregnanc Other (specify)	ey			ate of deliv	ery Day	Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions of	ontributing to death	but not resulting in the u	nderlying cause g	ven in Part I.		tobacco use cor			of death?
		Completed						pe 1 Tyes	riopsy riormed? 2 \(\textbf{N} \)	prior to co death?	opsy finding ompletion o	s available cause of
Z :	Physicien: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 16	Hospital: 1 🖳 Inpa	tient 2 ER/Outpatier	t 3 DOA Ot	hor	of Death Check on rsing Home 5 Re		her (Sneci	fv)	
	tel or Attending Phy s after death. al Director: After this ed in by the funeral d	Certification: 1	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of In (Month, D		Wo		28d. Describ	e how injury occu			
Divi	Hospitel or Att 24 hours after d Funeral Direct tely filled in by t		3 Suicide 6 Could not be determined	building,	njury - At home, farm, str etc. <i>(Specify)</i>			City or 1	(Street and Num own, State)			mber,
2	To the Hospitel within 24 hours a Mithin 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the bes iner: On the basis and manner:	st of my knowledge, deatl of examination and/or in- stated.	occurred at the to vestigation, in my	ime, date and opinion, deat	d place, and due to the h occurred at the time	e cause(s) and me, date and place	anner as s , and due t	stated. o the cause	9(s)
•	To the Ho within 24 I To the Fu completely	Me	29b. Signature and title of certifier August 20 Name and address of person who	/ m			200		29d. Date signo 2 2 2 4	106		
	Sta Registr		30. Name and address of person who of the second se	32. Regis	trar's Signature	-tent	··· f.	ce, hi	hen 1	no j	2-70	·>

DHMH 17 Rev 1/200

ORIGINAL

o type of the	in Black machbic mik	Elisare Ali Copies Are Legible.
State of Ma	ryland / Department of H	Health and Mental Hygiene 106

			1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of H <i>rtificate of L</i>			jieńeJUÖ eg. No.	00300
			1. Decedent's Name (First, Middle, Last,			-		2. Date of Deat	_	3. Time of Death
	Physici /Medic		Bertha Berkowitz					03/02/2	2006	8:45 PM
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Death	1
			Hebrew Home of G	ceater Wa	shington	Rockvil:	le		Montgome	ry
	Funeral		Social Security Number 6. Se	7. Ag	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	(Year) 9. Birth	nplace (State or Foreign untry)
	Director		000-10-01//	ZYZY.	99 Yrs.			10/30/1	1906 Germ	
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	vlaryl f sho	ō	DC		Hachingt.	on				1t∏Yes 2 □ No
	tha 28a	rect	DC 10e, Street and Number		Washingt	10f. Zip Code		1	0g. Citizen of What Cou	intry?
	3a or	ā	3339 Legation Str	et N.W.		20015			USA	,
	death ms 2	era	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spe		14. Race - Amer	ican Indian,
ထ	filed within 72 hours after death with the Maryland Hygiene. uther then "naturel", or Items 23a or 28a-f show ont, the Madical Examiner must be notified at	by Funeral Director	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2\X	No I			Rican, etc.)	Black, White	, etc.
21215-0036	rel', c	1 by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes XX No	Specify:		Specify: Whi	te
5	72 honatu	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occupa	lurina most of work	ina	16b. Kind of Business/l	ndustry
2	ithin Jen.	npl	Elementary/Secondary (0-12)	College (1-4or 5	i+) life.	DO NOT use retired,				
2	lad w tygiel her tl		12		Hom	e Maker			Own Home	
ance S	be fi	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		Maiden Sumame)	
چّ	d Mer d Mer narka natic	٦	Herman Kuflik	na Drian	105 11-11		Mary Sil			
Maryland	d 2 st th and 7 le r traur		19a. Informant's Name/Relationship (Ty						City or Town, State, Zi	
	1 an Heall em 2		Edward Berkowitz/ 20a. Method of Disposition	Step Son					gton, DC 20 20c. Location - City or T	
0	ages int of t: If it		1 🎇 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	1	osition (Name of matory or other place	00.40			,
Baltimore,	parmit. Pages 1 and 2 should be fliad within 72 hours after death with tha Marylan Department of Health and Mental Hygiene. Important: If item 27 le markad other then "naturel", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fureral Service Ligens	98		i Cemeter			Miami, FL Evans Funer	al Home
B	parmi Depa Impo any id		VIA		1.5				, MD 20715	ai nome
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused	the death. Do not en					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cause on each in	REBR	AL T	HODA	1BOSK		Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequence of):		17700		>	
	Examiner		Sequentially list conditions							
	D =	iner	Sequentially list conditions, if any heading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (ones	a on suquence of):				ĺ	
	ecute and trans	Examiner	that initiated events resulting in death) Last)						
90,	oe ex cian a		rossing in doubly East	Due to (or as	a consequence of):					
68760,	tificate be executed ig physician and as the burial-transit	edlcal		d			<u> </u>			
	ding se as		IF FEMALE:	3c. If yes, outcome	of pregnancy				204 0-4-44-5	
Box	eath a atten for u	clan	in the past 12 months?		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	Pery Day Year
o.	the d y the iched	ysl	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	umo or again.					
٩.	that ned b	by Physician/M	Part II. Other significant conditions con	ntributing to death b	ut not resulting in the u	nderlying cause give	on in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
g	quire; n sign							1 □ Ye	s 200 3□Pro	bably 4 Unknown
Division of Vital Records,	aw re	olete						24a. Was a		opsy findings available
æ	The late ha	Completed						autops perform		ompletion of cause of
<u>ra</u>	ien: rtifica stor, p	0	25. Was case referred to medical				26. Place of Death			20140
>	nysic nis ce direc	To B	examiner?	lospital: 1 🗌 Inpatie	nt 2 ER/Outpatier	nt 3 DOA Othe	Nursing Ho	ne 5 🗆 Reside	nce 6 □Other (Speci	ify)
0	ng Pt fter tf neral	:uc	27. Manaer of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time o	f 28c. Injury Work	at :	28d. Describe ho	w injury occurred	
Sio	endii eath. or: A the fu	catle	2 Accident investigation				fes 2 □ No			
Ž	or Atl fter d jrect n by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ury - At home, farm, str c. (Specify)	reet, factory, office		28f. Location (Str City or Town	reet and Number or Rur n, State)	al Route Number,
	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has baen signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Phys	ricians To the best	of much length and and and and and and	h occurred at the c	o data and in	and due to the	ause(s) and manner as	
	Hos 24 hc Fun etely	edical	(Check only 2 Medical Exami	ner: On the basis of and magner sta	examination and/or in	vestigation, in my op	inion, death occurr	and due to the ca ed at the time, da	ate and place, and due t	stated. to the cause(s)
	o the	Med	29b. Signature and title of certifier		(29c. License	number	29	9d. Date signed (Month,	Day, Year)
	->-0		· Sm	Town.	n min	100	01808	-4/1	MARCH 03	32006
			30. Name and address of person who co	mpleted cause of d	eath (Item 23a) (Type,	Print)		0	1	1
_			DINESH PAT	EL, my	0/21	montr	ose Rd	Nock	MARCH OF	20852
	Sta	_	3 Date filed (Month, Day, Year)		ar's Signature		/			
	Registr	al	₩ ΔR 0 3 200		24	- 0				

BERKOWITE.

				1 = For State Registrar AMEND#4 aperMD3	State of M /6/06,BMWQM		•	artment of tificate o		nd Mental	Hygien Reg. N	IIIIA	08382
		Physici	an	1. Decedent's Name (First, Middle, Las)					Mont	of Death h D	ay Year	3. Time of Death
		/Medio	cal	Keith F. Godsey, Jr. 4a. Facility Name (If not institution, give		tatio	013	4b. City, Town	, or Location of	Death		c. County of Deat	
	ne-h	Funeral Director		5. Social Security Number 6. Se 578–40–1419 11	helingie	ge (In yrs. Ia 86	ENTER	If Under 1 Ye Months Day		Hrs. 8. Date (Mont	of Birth 20, 191	9. Birth Viro	hplace (State or Foreign unity)
				Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
		the Mary 28a-f sh potified	Director	Maryland Harford 10e. Street and Number		Bel A	Air	10f. Zip Code			100.0	Citizen of What Co	1 Tes 25 No
		3a or	i Dir	224 East Broadway				21014	•		rog. c	USA	uritry ?
	936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Plyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show early injuryor other traumatic event, Ite Medical Examinar must be notified at ance.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces? 1 1 40s 2 1 If Yes, Give Year or Dates:	No No	1	Vas Decedent of f Yes, specify C		n? (Specify Yes Puerto Rican, etc	or No-	14. Race - Ame Black, White Specify.	e, etc.
	21215-0036	within 72 ho ane. than "natura ne Medical I	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation		16a. Deced (Give life. L	lent's Usual Oci kind of work doi DO NOT use ret nistrator	ne during most o ired)	f working		Kind of Business/	
	Maryland 2	uld be filed Mental Hygie irked other itic event, II	To Be Co	17. Father's Name (First, Middle, Last) Keith F. Godsey					18. Mother's	eah P. Ar	liddle, Maide		
	Aan	2 sho		19a. Informant's Name/Relationship (T								or Town, State, Z	(ip Code)
	Baltimore, I	Pages 1 and ent of Health nt: If Item 27		Leslie Gods y/ Daught 20a. Method of Disposition 1 Deurial 2 Cremation 3 Di 4 Donation 5 Other (Specify,	Removal from State	cei	ace of Dispo metery, cren	st Broadw sition (Name of natory or other p ven Cemet	place) M	ir, Maryl Date Darch 6, 2006	20c.	014 Location - City or rer Spring,	
	Balti	permit. I Departm Importar eny inju		21. Signature of Funeral Service Licens						uneral Ho , W., Sil	me Inc	ing, MD 20	
•		Physician and /Medical Examiner the parial-transit	dical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of the failure is the failure of the failure is the	Due to (or as Due to (or a) Du	Pim 1	ntia ence of):	er the mode of c	ying, such as ca	rdiac or respirat	ory arrest,		Approximate Interval Between Onset and Death
HIL	O. Box 6	ne death certifi the attending thed for use as	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. ff yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetaf	death 3	Ectopic pregna Other (specify)				23d. Date of deli Month	very Day Year
X	ds, P.	uires that It signed by Id be detac	by P	Part II. Other significant conditions co	ntributing to death t	out not resul	iting in the ur	nderlying cause	given in Part I.			-8	the cause of death?
SEY	al Recor	ysicien: The law requi is certificate has been s director, page 2 should	Completed							-	Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
2	Vital	ysicier s certif directo	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 🗆 E	R/Outpatien	t 3 DOA		Death Check of Death Ing Home		6 ☐ Other (Spec	2fv)
00	Division of	tending Phyleath loath lor: After thi the funeral	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Inju (Month, Da	ary (y Year)	28b. Time of Intury	28c. lr M 1	ury at /ork? ☐ Yes 2 ☐ No	28d. Desc	ribe how inj	ury occurred	
•	Divi	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer		4 Homicide determined		tc. (Specify)				City	or Town, Sta	te)	ral Route Number,
		e Hosp 24 ho e Fune letely fi	edicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	sicien: To the best ner: On the basis of and manner st	it examinatio	rledge, death on and/or inv	occurred at the restigation, in m	time, date and p y opinion, death	olace, and due to occurred at the	the cause(time, date a	s) and manner as nd place, and due	stated. to the cause(s)
		To the To the Comp	Me	29b. Signature and title of certifier	11 D				nse number			ate signed (Month	
	5	541		30. Name and address of person who c	ompleted cause of	death (Item :	23a) (Type,	Print)	7652	1 1	M	anch 1	2006
	7 5 30	Sta	te.	31. Date filed (Month, Day Year)	32. P ./ gisti	rar's Signatu	14	QVINU1	131/	HIV	Nur	ylund	alviy
		Registi		MAR 06	2006	ر میما	IF A	MARCH ST			,		

			1 - State Registrar	State of	Marylar	nd / Depa <i>Cei</i>			lealth a D <i>eath</i>	and M	lental Hy	giene Reg. No.	000		08383	
			1. Decedent's Name (First, Middle, I	Last)			-				2. Date of De	eath Day		eer	3. Time of Death	
	Physici /Medio		DONALD PAUL C	COOCH							March	02	20		10:20 PM	
1	Examin		4a. Facility Name (If not institution, g	rive street and nun	nber)			, .	Location of			1	County of			
			Holy Cross Hosp						Spri	_			ontgo			
١	Funeral		5. Social Security Number 6 579 • 54 • 3591	.Sex 1⊠M 2□F	7. Age (In yrs. 68	. last birthday) Yrs.	Month	er 1 Year S Days	If Under:	Min.	8. Date of Bir (Month, Da	h, Day, Year) Country)				
	Director		Usual Residence of Decedent					l			April	9, 19	13 / Wa	ashi	Ington, DC	
	yland		10a. State 10b. County		10c. C	ity, Town or Lo	cation							1	0d. Inside City Limits	
	Mar-fet	tor	Maryland Montgor	nery	Si	lver Sp	orin	g							1XYes 2 No	
	or 28	Director	10e. Street and Number			-	10f. 2	ip Code				10g. Citi	zen of Wha	at Coun	try?	
	23a	rai	2215 Solmar Dri	lve				20904				U.S	.A.			
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural; or items 23a or 28a-f show serving to other traumatic event, the Medical Examinar must be multiply a once.	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Dece Armed For 1 ☐ Yes If Yes, Giv	ces? 2 🔀 No		lf Yes, sp	edent of Hi ecify Cuba 28 No	ispanic Orig n, Mexican Specify:	gin? (Spe i, Puerto	cify Yes or No Rican, etc.)		Black,	White,	etc.	
9	ural',	d by	3 ☐ Widowed 4 ☒ Divorced	Year or Da	ites:		1 1 105	2428 IAO	Зреспу.				Specify: W	VIIIL	e 	
21215-0036	natu	Completed	15. Decedent's (Specify only highest of	Education grade completed)		16a. Deced (Give	kind of v	vork done o	during most	t of worki	ng	18b. Ki	nd of Busin	ness/Ind	lustry	
12	within sne.	dm	Elementary/Secondary (0-12)	College (1 4 Years				use retired	, nginee	- r		II.S	. Gov	ern	ment	
d 9	Hygie ther int,		17. Father's Name (First, Middle, La			Hech	anic	ar Di			(First, Middle					
Maryland	ould be Mental arked o	To Be	Theodore John	Gooch					Edit	th Gv	vladdiu	s Be	ndon			
Mar	12 sh h and 7 is m Irsum		19a. Informant's Name/Relationship								l Route Numb		210	42-	5004	
တ်	Healt Brit 2		Aileen J. Morris 20a. Method of Disposition	s/Sister	20b.	Place of Dispo	sition (N	ame of			llicott		y Ma cation - Cit			
ğ	S 5 = 5 P		1 ⊠ Burial 2 ☐ Cremation 3		State	cemetery, crer ce of H	natory of	other plac						•	g, Maryland	
Baltimore,	artme ortan injury	ı	4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		Gai									T T11	g, Maryrand	
Ã	Per Per Sup Sup Sup Sup Sup Sup Sup Sup Sup Sup		1 Name A	. Vanco	t	HI 11	NES- .800	RINAI New H	LDI FU Hampsl	ĴNERÆ hire	AL HOME	, IN Silve	C. r Spr	ing	, MD 20904	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that ca ly one cause on ea	used the dea ach line.										Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	. Myoca	rdial :	Infarct	ion							1	Onset and Death Hour	
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):									11041	
	Examiner		Sequentially list conditions,	_{b.} Hyper										1	0 Years	
	ed sit	Examiner	ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ading to immediate Due to to to as a consequence of.												
	cate be executed physicien and the burial-transit	xan	that initiated events resulting in death) Last	c. Due to (c								-			
8760,	be e	dicai E														
687	tificate ig phy: as the	edic		0.												
Вох	eath certif attending for use a	Ž.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo								2	3d. Date o	f delive	rv	
Ď.	death e atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregna	rth 2 □ Feta ant at time of c		JEctopic] Other (pregnancy specify)					Month		Day Year	
0.	at the de by the a tached	hys	9 Unknown	9□ Unkno	wn											
ds, ⊦	as tha	<u>۾</u>	Part II. Other significant conditions	contributing to de	ath but not res	sulting in the u	nderlying	cause give	en in Part I.			obacco u: Yes 2₹			e cause of death?	
S	w require been si should b	ete									24a. Was		24h Wor	o autor	osy findings available	
		Completed							-		auto	psy ormed?	prio dea	r to con th?	pletion of cause of	
/ita	ysician: nis certifica director, p	Be	25. Was case referred to medical examiner?							of Death	(Check only	опе)				
<u></u>	Physic this c	٤	1 ☐ Yes 2 ☒ No			ER/Outpatien			4 🗀 1901		ne 5□Resi			Specify)	
N C	ding Pt h. After th funeral	lon	27. Manner of Death 1 ☒ Natural 5 ☐ Pending		n, Day Year)	28b. Time of Injury	м	28c. Injury Work			8d. Describe	how injury	occurred			
<u>s</u>	ten deat tor: the	Icat	2 Accident investigat 3 Suicide 6 Could not	be On Blace	of Injuny - At h	ome, farm, str			/es 2□h		Rf Location /	Street and	Number	v Rura	Route Number.	
<u>></u>	after after Direction	Certification;	4 Homicide determine	g, etc. (Speci		oot, iacto	ry, onice		•	City or To		, vomber (n nora	noote Number,		
	To the Hospital or At within 24 hours after or To the Funeral Direction places of the Funeral Direction by	edical C	(Check only 2 Medical Ex	Physician: To the aminer: On the ba	sis of examina	owledge, death	occurre	d at the tim	ie, date and	d place, a	and due to the	cause(s)	and manne	er as st	ated.	
	To the h within 24 To the F complete	Medi	one)	and mann	er stated.											
	or vit		29b. Signature and title of certifier	5/2			- 1	9c. License					signed (A			
•	6		etter Pi	Merc	m	2		1219	110			Marc	h 3,	200	ь	
	4		30. Name and address of person where Peter B. Sherer				,	Who	ton	Marer	rland 2	0006				
	Sta	te.	31. Date filed (Month, Day, Year)		gistrar's Sign		1VE,	MILES	. CUII,	rialy	Tanu Z	0300				
	Registr			2006	BOAR S	is payor										

		1 - State Registrar			Ce.	rtificate of	Death			Reg. Nb.	and the same	0000
		1. Decedent's Name (First, Middle	, Last)						2. Date of De	ath	V	3. Time of Death
Physici /Medio		CAROLYN JUNE	BECKER						Month March	04	2006	4:00 A
Examir		4a. Facility Name (If not institution,	, give street and n	umber)		4b. City, Town, o	or Location	of Death		4c. C	ounty of Death	1
		Joseph Richie	Hospice			Baltin						
Funeral Director		225.46.4663	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yr. 69	s. last birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Bir (Month, Da Feb. 26	$\stackrel{\text{th}}{\stackrel{\text{ly, }}{\stackrel{}{}}} 193$	9. Birth Cou E1ki	nplace (State or Fore untry) .ns, W.V.
pu &		Usual Residence of Decedent 10a. State 10b. County		100 (City, Town or Lo	cation						10d. Inside City Lim
h the Marylan r 28a-f ehow	ŏ	Maryland Prince	Canrae!		College							1 X Yes 2 □
28a-1	Director	10e. Street and Number	ocorge c			10f. Zip Code				10a Citiza	en of What Cou	
With Po and	ă	5019 Edgewood R	oad.			20740				U.S.		andy:
heath ne 23	era	11. Marital Status		cedent Ever in	U.S. 13.		Hispanic Ori	gin? (Sp	ecify Yes or No		l. Race - Amer	ican Indian.
within 72 hours after death with the Maryland ene. Than "naturel; or iteme 23e or 28e-f ehow na Medical Examiner must be notitied at	by Funeral	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed F	Forces?		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☒ No			Rican, etc.)	i	Black, White Specify: Whi	, etc.
sture		15. Decedent			16a, Dece	dent's Usual Occur	pation			16b. Kind	d of Business/le	ndustry
n n	Completed	(Specify only highes		(1-4or 5+)	(Give	kind of work done DO NOT use retire	during mos	t of work	ing			,
d within	E	Elementary/Secondary (0-12) 12th	College	(1-40/ 5+)	Воо	k-Keeper				Cons	structi	on
2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M	a	17. Father's Name (First, Middle, L	Last)				18. Mothe	er's Name	e (First, Middle,	, Maiden S	umame)	
henta ked ic ev	To B	Walter Lee					Evel	Lyn	Stalna!	ker		
permit. Pages 1 and 2 should be Department of Heelth and Ments Important: If item 27 is marked any injury or other traumatic events.	-	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailie	ng Address (Street	and Numbe	er or Rura	al Route Numb	er, City or 1	Town, State, Zi	ip Code)
alth a		Elizabeth A. Vi	illa/Daug	ghter	5606	Saint Al	lbans	Way,	Baltin	more,	Maryla	ind 21212
2 ± = = = = = = = = = = = = = = = = = =	-	20a. Method of Disposition			. Place of Dispo	osition (Name of matory or other pla	(00)	- 1	Date	20c. Loca	ation - City or T	Town, State
	ļi.	1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		n State FC		coln Crem		3/1	0/2006	Brent	wood,	Maryland
orta	1	21. Signature of Funeral Service L			22	2. Name and Addre	ess of Facilit	ly	2			
Ped Fire S		No. and A		7:	H.	LNES-RINA	LDI F	UNER	AL HOME	INC	Saria	g, MD 209
		23a. Part1. Enter the disasse, or shock, or heart	complications that			LOOU NEW	mamps	TITTE	Ave, b	TIVEL	оргти	g, FID 20:
		shock, or heart there. List of		caused the de	ath. Do not ent	er the mode of dyi	ng, such as	cardiac (or respiratory a	rrest,		Approximate
Physician		Immediate Cause (Final	1	10	ath. Do not ent				-			Onset and Deat
		Immediate Caus (Final disease or condition resulting in death)	-a. Lua	16 Ca	NCER				or respiratory a			Onset and Deat
/Medical		disease or condition resulting in death)	-a. Lua	10	NCER				-			Onset and Deatl
Medical	er	disease or condition resulting in death)	a. Luad Due to	16 Ca	equence of):				-			Onset and Death
Medical xaminer	miner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. Luad Due to	o (or as a conse	equence of):				-			Onset and Death
Medical xaminer	Examiner	disease or condition resulting in death)	a. Luado Due to b. Due to c.	o (or as a conse	equence of):				-			Onset and Death
Medical xaminer	Examin	disease or condition resulting in death) Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Luado Due to b. Due to c.	o (or as a conse	equence of):				-			Onset and Death
hysician and hysician and he burial-transit	edicai Examin	disease or condition resulting in death) Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Luado Due to b. Due to c.	o (or as a conse	equence of):				-			Onset and Death
Medical hysician and hysician a	edicai Examin	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Lucato Due to c	o (or as a conse	equence of): equence of):	CHON	Suga		-	<i>)</i>	d. Date of deliv	Approximate Interval Between Onset and Death
hysician and hysician and hysician and hysician the burial-transit	edicai Examin	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	a. Luad Due to c	o (or as a consection of or as a consection or a consection of or as a consection or a consection of or as a consection or a consection or a consection of	equence of): equence of): equence of):		Suga		-	<i>)</i>	d. Date of delive	Onset and Death
hysician and hysician and hysician and hite burial-transit	edicai Examin	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	a. Luck Due to b. Due to d. 23c. If yes, o	o (or as a consection of or as a consection or a consection of or as a consection or a consection of or as a consection or a consection or a consection of	equence of): equence of): equence of):	Ho K	Suga		-	<i>)</i>		Onset and Death
hysician and hysician and hysician and hysician the burial-transit	Physician/Medical Examin	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	a. Due to b. Due to c. Due to d. 23c. If yes, o 1 □ Live 4 □ Preg 9 □ Unk	o (or as a consection of or as a consection or a consection of or as a consection or a consection of or as a consection or a consect	equence of): equence of): equence of): equence of): equence of): financy equence of):	Ectopic pregnance	Sugar v	ter	CEU	23	Month	Onset and Deat
Medical hysician and hysician a	by Physician/Medical Examin	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant condition	a. Due to b. Due to c. Due to d. 23c. If yes, o 1 □ Live 4 □ Preg 9 □ Unk	o (or as a consection of or as a consection or a consection of or as a consection or a consection of or as a c	equence of): equence of): equence of): equence of): equence of): financy equence of):	Ectopic pregnance	Sugar v	ter	CELL 23e. Did to	23	Month a contribute to	Onset and Death Onset and Death Very Day Year
hysician and hysician and the burial-transit	by Physician/Medical Examin	disease or condition resulting in death) Sequentially list conditions, in any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition	a. Due to b. Due to c. Due to d. 23c. If yes, or 1 Live 4 Preg 9 Unk	o (or as a consection of or as a consection or a consection of or as a consection or a consection of or as a c	equence of): equence of): equence of): equence of): equence of): financy equence of):	Ectopic pregnance	Sugar v	ter	23e. Did t	23 obacco use Yes 2	Month a contribute to	onset and Death Year Year the cause of death bababiy 4 □Unkn
hes been signed by the attending physician and HP per should be detached for use as the burial-transit	by Physician/Medical Examin	disease or condition resulting in death) Sequentially list conditions, in any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition	a. Due to b. Due to c. Due to d. 23c. If yes, or 1 Live 4 Preg 9 Unk	o (or as a consection of or as a consection or a consection of or as a consection or a consection of or as a c	equence of): equence of): equence of): equence of): equence of): financy equence of):	Ectopic pregnance	Sugar v	ter	23e. Did to	23 obacco use Yes 2	Month e contribute to No 3 Pro 24b. Were aut prior to codeath?	onset and Death Year Year the cause of death bababiy 4 □Unkn
ote has been signed by the attending physician and mapage 2 should be detached for use as the buriat-transit	Completed by Physician/Medical Examin	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition	a. Due to b. Due to c. Due to d. 23c. If yes, or 1 Live 4 Preg 9 Unk	o (or as a consection of or as a consection or a consection of or as a consection or a consection of or as a c	equence of): equence of): equence of): equence of): equence of): financy equence of):	Ectopic pregnance	y ven in Part I	ter -	23e. Did to 1 1 24a. Was autop perfo	23 obacco usee Yes 2 obacco use Yes 2 obacco use Yes 2 obacco use Yes 2 obacco use	Month a contribute to No 3 Pro 24b. Were aut	onset and Death Year Year the cause of death babably 4 □Unkn
ate has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	Be Completed by Physician/Medical Examin	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions BRAIN (SE)	a. Due to b. Due to c. Due to d. 23c. If yes, or 1 Live 4 Preg 9 Unk	o (or as a consection of or as a consection or a consection of or as a consection or a c	equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of):	Ectopic pregnancy Other (specify)	y ven in Part I.	of Death	23e. Did to 1 24a. Was autor performance of Check only of the control of the cont	23 obacco use Yes 2 an an ssy rrmed? 2 No one)	Month No 3 □ Pro 24b. Were aut prior to or death? 1 □ Yes	onset and Death Very Day Year the cause of death babiy 4 □Unkn opsy findings avail ompletion of cause
Tripstrian: The law requires that the death certificate be executed. This certificate has been signed by the attending physician and be detached for use as the burial-transit or is all director, page 2 should be detached for use as the burial-transit.	To Be Completed by Physician/Medical Examin	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions BRAIN (SE)	a. Due to b. Due to c. Due to d. 23c. If yes, o 1 Live 4 Preg 9 Unk ns contributing to	o (or as a consect of or as a co	equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of):	Ectopic pregnance Other (specify) nderlying cause grounderlying groun	y ven in Part I. 26. Place	of Death	23e. Did to 1 24a. Was autor performance of Check only of the control of the cont	obacco use Yes 2 an an asy rmad? 2 PNo one) dence 6	Month No 3 Pro 24b. Were aut prior to co death? 1 Yes	onset and Death Year The cause of death bably 4 □Unkn opsy findings avail ompletion of cause
After this certificate hes been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical Examin	disease or condition resulting in death) Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition BRACK (FE) 25. Was case referred to medical examiner? 1 Yes 2 No 9 Yes 2 No 9 Yes 2 No 9 Yes 2 No 9 Yes 2 No 9 Yes 2 No 9 Yes 2 Yes	a. Due to b. Due to c. Due to d. 23c. If yes, o 1 Live 4 Preg 9 Unk ns contributing to ASTASS Hospital: 28a. Date (Mo.	o (or as a consection of or as a consection or a consection of or as a consection or a c	equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of):	Ectopic pregnanc	y 26. Place Per: 4 Nu Nu Ny at	of Death	23e. Did to 1 24a. Was autor performance of Check only of the control of the cont	obacco use Yes 2 an an asy rmad? 2 PNo one) dence 6	Month No 3 Pro 24b. Were aut prior to co death? 1 Yes	onset and Death Year The cause of death bably 4 □Unkn opsy findings avail ompletion of cause
beath. tor: After this certificate hes been signed by the attending physician and B between the funeral director, page 2 should be detached for use as the burial-transit D D D D D D D D D D D D D D D D D D D	To Be Completed by Physician/Medical Examin	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 3 Yes 3 Yes 3 Yes 3 Yes 3 Yes 3 Yes 3 Yes 4 Yes 4 Yes 4 Yes 4 Yes 4 Yes 5 Yes 4 Yes 5 Yes 4 Yes 5 Yes 4 Yes 5 Yes 5 Yes 6 Yes 7 Yes 6 Yes 7 Yes 6 Yes 6 Yes 6 Yes 6 Yes 6 Yes 6 Yes 6 Yes 7 Yes 6 Yes 6 Yes 6 Yes 6 Yes 6 Yes 6 Yes 6 Yes 7 Yes	a. Due to b. Due to c. Due to d. 23c. If yes, o 1 Live 4 Preg 9 Unk ns contributing to A STASS atton of be 23a. Date (Mo	o (or as a consection of or as a consection	equence of): equen	DEctopic pregnance Other (specify) Inderlying cause give At 3 DOA Other 28c. Injun World M 1	y ven in Part I. 26. Place	of Death	23e. Did to 1 24a. Was autor performence of Check only of the control of the cont	obacco use Yes 2 an an any yer 2 No one) dence 6	Month a contribute to: No 3 pro 24b. Were aut prior to code and ? 1 yes X Other (Special Contribute)	onset and Death
Iter death. Iter death. Sire death. Director: After this certificate hes been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit of in by the funeral director.	To Be Completed by Physician/Medical Examin	disease or condition resulting in death) Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition BRACN (FE) 25. Was case referred to medical examiner? 1 Yes 2 No 9 Value of the condition of the past 12 months?	a. Due to b. Due to c. Due to d. 23c. If yes, or 1 □ Livre 4 □ Preg 9 □ Unk ns contributing to ASTAS Hospital: 1 □ 28a. Date (Mo atton of be 28e. Plac	o (or as a consection of or as a consection	equence of): eq	Ectopic pregnanc	y 26. Place Per: 4 Nu Nu Ny at	of Death	23e. Did to 1 24a. Was autor performence of Check only of the control of the cont	obacco use Yes 2 1 an an an any yrmed? 2 1 No one dence 6 how injury of	Month a contribute to: No 3 pro 24b. Were aut prior to code and ? 1 yes X Other (Special Contribute)	onset and Death Year The cause of death bably 4 Dunkni opsy findings avail ompletion of cause
or Attending Physician: The law requires that the death certificate be executed the requires that the death certificate be executed the requirement of the remaining physician and the rector. After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit of the remaining physician and the remaining physician	Certification; To Be Completed by Physician/Medical Examin	disease or condition resulting in death) Sequentially list conditions. If any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to b. Due to c. Due to d. 23c. If yes, or 1 Live 4 Preg 9 Unk ns contributing to ASTASS Hospital: 28a. Date (Mo. ation of be ned 28e. Plac built g. Physician: To the examiner: On the	o (or as a consection of or as a consection	equence of): eq	DEctopic pregnance Other (specify) Inderlying cause give At 3 DOA Other 28c. Injun World M 1	y y yen in Part I. 26. Place her. 4 \(\text{Nu} \) Nu y at rk? I Yes 2 \(\text{III} \)	of Death	23e. Did to 1 24a. Was autor performe 5 Resident City or Toward due to the	obacco use Yes 2 an Day Image: I	Month No 3 Pro 24b. Were aut prior to codeath? 1 Yes X Other (Special Control of the Control	onset and Death Year The cause of death bably 4 Dunknow Opsy findings avail Ompletion of cause 20 No
X Meeter. After this certificate hes been signed by the attending physician and B phin by the funeral director, page 2 should be detached for use as the burial-transit D D D D D D D D D D D D D D D D D D D	To Be Completed by Physician/Medical Examin	disease or condition resulting in death) Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition BRACN 25. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown 27. Manner of Death 1 Natural 5 Pending investig 2 Accident 3 Suicide 4 Homicide 4 Homicide 29a. Certifier (Check only 2 Medical E	a. Due to b. Due to c. Due to d. 23c. If yes, or 1 Live 4 Preg 9 Unk ns contributing to ASTASS Hospital: 28a. Date (Mo. ation of be ned 28e. Plac built g. Physician: To the examiner: On the	o (or as a consection of or as a consection	equence of): eq	DEctopic pregnance Other (specify) Inderlying cause give At 3 DOA Other At 3 DOA Other Month 1 Calculate the full occurred at the f	26. Place ner: 4 \(\text{Nu} \) ny at rk? I Yes 2 \(\text{I} \) me, date an opinion, dea	of Death	23e. Did to the satisfied of the control of the con	obacco use Yes 2 1 an osy rmed? 2 1 bown injury of the win, State) cause(s) are date and p	Month No 3 Pro 24b. Were aut prior to codeath? 1 Yes X Other (Special Control of the Control	onset and Death Year The cause of death bably 4 Dunknic Opsy findings avail ompletion of cause 20 No ify) A SPIC ral Route Number, stated. to the cause(s)
Iter death. Sirector: After this certificate has been signed by the attending physician and point by the funeral director, page 2 should be detached for use as the burial-transit of points.	edical Certification; To Be Completed by Physician/Medical Examin	disease or condition resulting in death) Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to b. Due to c. Due to d. 23c. If yes, or 1 Live 4 Preg 9 Unk ns contributing to ASTASS Hospital: 28a. Date (Mo ation of be ned 28e. Plac built g. Physician: To the examiner: On the	o (or as a consection of or as a consection	equence of): eq	DOA Ott at 3 DOA Ott f 28c. Injunyon M 1 ceet, factory, office th occurred at the twe trigation, in my of the course of the	26. Place ner: 4 Nu ry at rk? Yes 2 I	of Death	23e. Did to the satisfied of the control of the con	obacco use Yes 2 1 an an an an an an an an an an an an an	Month No 3 Pro 24b. Were aut prior to condeath? 1 Yes Cocurred Number or Run Indimanner as a lace, and due to signed (Month).	onset and Death Year The cause of death bably 4 Dunknic Opsy findings avail ompletion of cause 20 No ify) A SPIC ral Route Number, stated. to the cause(s)
Iter death. Sirector: After this certificate has been signed by the attending physician and point by the funeral director, page 2 should be detached for use as the burial-transit of points.	edical Certification; To Be Completed by Physician/Medical Examin	disease or condition resulting in death) Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition BRACN (SE) 25. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown 27. Manner of Death 1. Natural 5 Pending investig: 3 Suicide 4 Homicide Germin determined Significant conditions Suicide Germined Germine	a. Due to b. Due to c. Due to d. 23c. If yes, or 1 Live 4 Preg 9 Unk ns contributing to ASTAS Hospital: 1 28a. Date (Mo atton of be ned 28e. Plac built g Physician: To the examiner: On the and ma	o (or as a consection of or as a consection	equence of): equen	Deet, factory, office	26. Place ner: 4 \(\text{Nu} \) ny at rk? I Yes 2 \(\text{I} \) me, date an opinion, dea	of Death	23e. Did to the satisfied of the control of the con	obacco use Yes 2 1 an osy rmed? 2 1 bown injury of the win, State) cause(s) are date and p	Month No 3 Pro 24b. Were aut prior to condeath? 1 Yes Cocurred Number or Run Indimanner as a lace, and due to signed (Month).	onset and Death Year The cause of death bably 4 Dunknic Opsy findings avail ompletion of cause 20 No ify) A SPIC ral Route Number, stated. to the cause(s)
1990). 1990). 1990). 1990). 1990). 1990 Should be detached for use as the burial-transit.	edical Certification; To Be Completed by Physician/Medical Examin	disease or condition resulting in death) Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to b. Due to c. Due to d. 23c. If yes, or 1 Live 4 Preg 9 Unk ns contributing to ASTAS Hospital: 1 28a. Date (Mo atton of be ned 28e. Plac built g Physician: To the examiner: On the and ma	o (or as a consection of or as a consection	equence of): equen	Deet, factory, office	26. Place ner: 4 Nu ry at rk? Yes 2 I	of Death	23e. Did to 1 24a. Was autor performed to the control of the contr	obacco uses an an any any any any any any any any an	Month Percentification of the contribute to the	onset and Death Year The cause of death bably 4 Unkn opsy findings avail ompletion of cause 25 No ify) A SPIC ral Route Number, stated. to the cause(s)

			1 - State Registrar	State of Mary		artment of h rtificate of			giene Reg. No.	06 (8385
			1. Decedent's Name (First, Middle, Last)					2. Date of De	ath Day	Voor	3. Time of Death
	Physici /Medic		Annie Amelia Bo	xall				March		006 Year	2:55 p M
	Examin		4a. Fecility Name (If not institution, give s	treet and number)		4b. City, Town, o	or Location of Deat	th	4c. C	County of Death	
			Holy Cross Hospit	al			Spring		Mo	ontgomer	cy.
I	Funeral Director		5. Social Security Number 6. Sex 216-18-0753 1□	7. Age (In	yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days			th 19, Year) 15, 19	9. Birthp Caur 918 Vii	lace (State or Foreign ntry) ginia
	P .		Usual Residence of Decedent								
	hrylar show	_	10a. State 10b. County	100	c. City, Town or Lo	cation				1	0d. Inside City Limits
	8e-1	cto	Maryland Montgome	ry S	Silver Sp						1 ☐ Yes 2 No
	vith th	Dire	10e. Street and Number			10f. Zip Code			10g. Cilize	en of What Cour	ntry?
	ath v	La L	908 Laredo Road			20901			T.	USA	
21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 ie marked other then "natural", or iteme 23e or 28e-f ehow important: in Item 27 ie marked other then "natural", or iteme 25e or 28e-f ehow en injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 🖾 Widowed 4 Divorced	2. Was Decedent Ever Armed Forces? 1 ☐ Yes ※ Young If Yes, Give Year or Dates:		Was Decedent of F f Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	}	4. Race - Americ Black, While, SpecifyWhite	elc.
0-0	72 ho	ted	15. Decedent's Educ (Specify only highest grade	alion	16a. Dece	dent's Usual Occup	pation during most of wo	etrice.	16b. Kind	d of Business/Ind	dustry
2	en "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	id) most of wo	rking			
2	ed wi	Con	9	10 10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Hon	nemaker	· · · · · · · · · · · · · · · · · · ·			Own H	Iome
p	d oth	Be	17. Father's Name (First, Middle, Last)					me (First, Middle,			
<u>Ş</u>	Men Men Marke	70	Elisha Eppa Sutha					le Alice			
Maryland	12 sh and 7 io m		19a. Informant's Name/Relationship (Type Leslie J. Behne/ D	•			and Number or Ru Prince				Code)
a)	1 end 1 eath		20a. Method of Disposition					Date		ation - City or To	Ctata
Baltimore,	Se in in in in in in in in in in in in in		1 Burial 2 ☐ Cremation 3 ☐ Re	MINOVALITORI STATE		sition (Name of natory or other pla		ch 9,			
를	ntan nlucy		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License			s Cemetery					Maryland
Ba	Deperiment of the periment of		Ville Ellow	S	50	0 Univer	coffins sity Blv	Funeral d, W, Si	Home lver	Inc. Spring,	MD 20901
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the caused the cause on each line.	death. Do not ent	er the mode of dyi	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
)	Physician		Immediate Cause (Final disease or condition resulting in death)	Sepsis							Unknown
	/Medical Examiner		resulting in death)	Due to (or as a cor							1
	.8:	_	Sequentially list conditions, b	Urinary Tr		ction					Unknown
	ted nslt	Examiner	if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of).							
	ificate be executed g physicien and as the burial-transit	xar	that initiated events c. resulting in death) Last	Due to (or as a cor							
68760,	sicier sicier	alE									
687	ificate p phy as the	edical									
Вох	nding use a	2	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pr					23	d. Date of delive	nry
Ď.	thet the death certifined by the attending	Physician/M	in the past 12 months? 1 □ Yes 2 ☑ No	1 Live birth 2 □ 4 Pregnant at time]Ectopic pregnanc;] Other <i>(specify)</i> _	у			Month	Day Year
Р. О.	by the	hys	9 Unknown	9□ Unknown							
	The law requires thet the death certi lie hes been signed by the attending age 2 should be detached for use a	by P	Part II. Other significant conditions con	ributing to death but not	t resulling in the u	nderlying cause giv	ven in Part I.	23e. Did to	obacco use	e contribute to Ih	e cause of death?
g	w require been sign	ed	Diabetes Mellitus					101	/es 2 X □	No 3 ☐ Prob	ably 4 □Unknown
သွ	hesbe hesbe je 2 sho	Completed						24a. Was		24b. Were auto	psy findings available
œ .	The ste he	ĕ							rmed?	death?	npletion of cause of
<u>i</u>	ysician: The is certificate hi director, page	Be	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only o			
Ž	hysic his ce I dire	2	1 □ Yes 2 ☑ No	ospital: 1 Anpatient	2 ER/Outpatien	t 3□ DOA Ott	ner: 4 🗆 Nursing H	Home 5□ Resid	dence 6	□Other (Specify	1)
Ç.	Attending Physician: or death. octor: After this certifici by the funeral director,		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Dale of Injury (Month, Day Yea	28b. Time of Injury	28c. Injui	ry at rk?	28d. Describe h	now injury	occurred	
<u> </u>	tendin leath. tor: Af the fur	catl	2 Accident investigation 3 Suicide 6 Could not be			M 1	Yes 2 No				
Division of Vital Records,	ai or At s after of ii Direct id in by	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (Sp	At home, farm, str pecify)	eet, factory, office		28f. Location (S City or Tox		Number or Rura	I Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Medical (29a. Certifier Cartifying Phys	cian: To the best of my er: On the basis of exar and manner stated.	knowledge, death mination and/or in-	n occurred at the till vestigation, in my o	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) a date and p	nd manner as st lace, and due to	ated. the cause(s)
	ro th	Me	29b. Signature and title of certifier			29c. Licens			29d. Date	signed (Month, i	Day, Year)
			> AA	wh		d6	3738			March 2	, 2006
1	0		30. Name and address of person who cor								
_			Anjuman Ara, M.D.				ver Spri	ng, MD 2	0910		
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's S	ignature	ulli	-				

			1 - For State Registrar		of Maryland		artment of tificate of				Reg. No.	006	08386
	Physici		1. Decedent's Name (First, Middle Rita Ann Bro							2. Date of Dea Month March		006 Year	3. Time of Death 9:21a M
1	/Medic Examin		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City, Town,	or Location o	of Death		4c. Co	ounty of Deatl	h
			2713 Weller Ro	ad			Silver	Sprin	_		ľ	Montgor	mery
	Funeral Director		5. Social Security Number 305-24-4686	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. la 79	as <i>t birthday)</i> Yrs.	If Under 1 Yea Months Days		Min.	8. Date of Birt (Month, Day Oct. 3]	v. Year)	Co	nplace (State or Foreign untry) ndiana
	pud *		Usual Residence of Decedent 10a. State 10b. County		10c City	. Town or Lo	cation						10d. Inside City Limits
	Aaryli	ច											1 ☐ Yes 21 No
	28e-	Directo	Maryland Montgo	mery	511	ver S	10f. Zip Code				10g, Citize	n of What Co	untry?
	3a or		2713 Weller Roa	ď			20	906				SA	, .
	death	Funerai	11. Marital Status	12. Was Dec	edent Ever in U.S	S. 13. V	Vas Decedent of Yes, specify Cu		gin? (Spec	cify Yes or No-		Race - Ame	
9	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "naturel", or iteme 23s or 28s-f show event, the Madical Examinar must be notified at		1 Never Married 2 Marrie	If Yes, Gi	2 JNo ve		Yes 2√⊡ N		i, Fuello A	ticari, etc.)		Black, White pec <i>ify:</i> Wh:	
215-0036	ture!	ed by	3 Widowed 4 Divorced	Year or E	Dates:	160 Decor	lent's Usual Occi	tion					
Ç	in 72 n "na	Completed	15. Decedent (Specify only highest	grade completed)		(Give	kind of work don	e during most	t of workin	g	100. Killa	of Business/I	industry
212	yiene.	Шо	Elementary/Secondary (0-12)	Cotlege (stess				Rest	taurant	ŧ.
פ	e filed al Hygi other vent, I	Bec	17. Father's Name (First, Middle, L	ast)				18. Mothe	r's Name	(First, Middle,			
Maryland 21	should be ind Mental marked o	To	Nicholas Smith					An	n Ste	eed 			
<u>a</u>	2 she and te m	6 3	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailin	g Address (Stree	at and Numbe	r or Rural	Route Numbe	ar, City or T	own, State, Z	(ip Code)
e) O)	1 and Health em 27 ther tr		John J. Broda/ 20a. Method of Disposition	Husband	20h BI		Weller	Road,		er Spri			
Baltimore,	Pages nent of the unt: If its ury or of		1 ⊠ Burial 2 ☐ Cremation		State C6	metery, cren	natory or other player. Even Cemet	1 1	March	7,		tion - City or	
	. 5 5 4		4 □Donation 5 □ Other (Sp 21. Signature of Funeral Service L	A	Gau			1	2006	-			ng, Marylan
n n	Depart Import eny in	5 5	Ar Collins	Uttal			Name and Add O Unive						, MD 20901
			23a. Part Enter the disease, or shock, or heart failure. List of	complications that only one cause on	caused the death	. Do not ente	ar the mode of dy	ring, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		e Cerebr		ılar Epi	sode (Strok	se)			Unknown
	Examiner			Due to	(or as a consequ	ence of):							
		Jec	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(vi as a consequ	ence of).							
	death certificate be executed e attending physiclen and id for use as the burial-transit	Examin	that initiated events	c.									
Ď,	e exe												
8/60	cate b	dica		d								-	
×	leath certifica attending ph I for use as th	/Me	IF FEMALE:	23c. If ves. ou	tcome of pregnar	ncv					224	d. Date of deli	
ROX	atter 1 for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No	1 Live I	oirth 2 Fetal nant at time of de	death 3	Ectopic pregnan Other (specify)	су			230	Month	Day Year
j.	t the c by the	Physician/Medical	9 Unknown	9□ Unkn	own								
ecords, P	w requires that the de been signed by the should be detached	ρ	Part II. Other significant condition	ns contributing to d	eath but not resu	Iting in the ur	iderlying cause g	iven in Part I.					the cause of death?
င္ပ	law req as beer 2 shou	ete								24a. Was	an 2	24b. Were au	topsy findings available
Ä	sician: The law certificete has t irector, page 2 s	Completed								autop perfor	rmed?	prior to death? 1 ☐ Yes	completion of cause of
VITAI H	ian: ntifice ctor, p	BeC	25. Was case referred to medical examiner?					26. Place	of Death	(Check only o			
0	Physician: this certifice ral director, I	2	1 ☐ Yes 2 ☒ No			EP/Outpatien	1 30 DOX		rsing Hom	e 5 🖾 Resid	lence 6	Other (Spec	cify)
	fer	inol.	27. Manner of Death 1 ☑Natural 5 ☐ Pending		of Injury oth, Day Year)	28b. Time of Injury	W		1	8d. Describe h	now injury o	occurred	
DIVISION	Attending r death. sctor: After by the fune	icat	2 Accident investig	ot be 300 Place	of Injury - At hor	ne farm stre		Yes 2 1		Rf Location (S	Stroot and A	Number or Ru	ral Route Number.
2	tel or A	Certification:	4 Homicide determine	build	ing, etc. (Specify,)	set, factory, office	,		City or Ton		varnosi oi ria	rai riouto rumbor.
	To the Hospitei or Attendi within 24 hours after death. To the Funerei Director: A completely filled in by the to	dicai	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the examiner: On the b and man	e best of my know easis of examinati ner stated.	vledge, death ion and/or inv	occurred at the estigation, in my	time, date and opinion, deat	d place, ar th occurre	nd due to the o	cause(s) ar date and pl	nd manner as ace, and due	stated. to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	0 0				se number			29d. Date s	signed (Month	n, Day, Year)
)	15		Josme	C- /	the, 2	NO	Do	03472	26		Marc	h 2, 2	2006
			30. Name and address of person v Jasmine Gatti,		se of death (Item 18 Wisco			Bethes	da, N	MD 2081	.4		
ı	Sta Registr		31. Date filed (Month, Day, Year) MAR 06	2006	legistrar's Signat	шгө	alle						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Ind. 1tems 4a, c, 20b, 21, 22, 25 per doc g853 3-20-06 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2000 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician Craig Joseph Bernard 4:02PM Feb 2006 /Medical Facility Name (If not institution, give street and number)
Southern Maryland Hospital 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern MD 5. Social Security Number Clinton Prince George's Ílome Surrat If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Months Director 67 May 18 1938 N Carolina 238 56 6164 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f ehow other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Chesapeake VA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Itams 23a USA 872 Bells Mill 23320 Completed by Funeral Rd death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after anent of Health and Mental Hygiene. 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married ŏ 1 ☐ Yes 2 🖳 💥o Baltimore, Maryland 21215-0036 Specify: Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Service Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Katie Craig Lois Craig ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chesapeake, Va 23320 item 27 I 872 Bells Mill Rd. Tonya Lovell Daughter Feb. 18. 2006 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State ŏ Department of Importent: If eny injury or one Chesapeake Va Feb 18 Roosevelt Memorial 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Liloyd M. Estep 22. Name and Address 225 Norview Ave. Norfolk, VA. 23513 Clas per dvr Riddick Funeral Service 1225 Norview 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ARTHGROSCIGROTIC CARDIOVASCULAR DISGASE disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) P.O. | the 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 6 Division of Vital Records, should be MELLITUS, HYPERTENSION 1 Yes 2 No 3 Probably 4 Onknown Completed FAILURE DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? certificate 1 Tes 2 1 No or Attending Physicien: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Yes 2 No 1 Inpatient 2 PER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred ofter death. Director: After t 1 ☑Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident filled in by the 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours e To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ATTENDING PHYSICIAN D 52900 02-06-2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CENTRAL AV # 301, LANDOVER MD 20185 MUSA MOMOH 2700 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 27 2006 4:00 P February Maggie Elizabeth Cox /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Laurel Regional Hospital Laurel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 ☐ M 2 🛣 F Oct. 31, 1920 Director 228-56-9920 Virginia Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b. County 10c. City. Town or Location 10a State 28a-f ehow ral', or items 23a or 28a-f ehov Examiner must be notified at 1X Yes 2 ☐ No Director Ne1son Virginia Shipman 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code be filed within 72 hours after death wintal Hygiene.

ed other than "natural", or items 23s cevent, the Model Exampler from the 22971 47 Braddock Lane United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Specify: Black 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th Cook Nelson Co. Schools 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any linjury or other traumatic event page. Be Jannie A. Hickman John P. Martin, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 68, Lovingston, VA 22949 Ann Briggs/Sister 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Cox Family Cemetery | 3/5/2006 4 □ Donation 5 □ Other (Specify) Shipman, VA 21. Signatur of Fune al Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 oven 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 1 Day Sepsis **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Urinary Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760. Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown s been signed b 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Heart Failure, Cardiomyopathy, Dementia, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an Renal Failure, Deep Venous Thrombosis, 2 No 1 Yes Gastro Intestinal Bleeding Division of Vital After this certification funeral director, I Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Pending Hospital or Attendin 24 hours after death. Funeral Director: Aff 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) illed in by 4 Homicide o the Huseritin 24 hours.
To the Funeral D' 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) D23181 February 27, 2006 2 e 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 704 Gorman Ave., #T-1, Laurel, MD R.G. Bhojraj, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 6 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 8:40 Virginia Conaway 4. County of Death march /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 21804 SALISBURY REHAB & NURSING CENTER SALISBURY, MD. WICOMICO Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🗙 F 160-14-5880 MD Director 86 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County 1 Yes 2 No Director Wicomico Parsonsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Iteme 23a 31598 Morris Leonard Rd. 21849 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married ö 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 X Widowed 4 □ Divorced "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home other f Health and Mental Hyg item 27 is marked other other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last, Be Pages 1 and 2 should be 1 nent of Health and Mental Reese M. Scott Margie Smack ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert Conaway 31598 Morris Leonard Rd., Parsonsburg, MD 21849 Important: If item. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 3/8/2006 Bates Cemetery Snow Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licenses 108 William St., Berlin, MD 21811 22a. Part1. Enter he disease, or complications that caused the ceath. shock, or hear failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Que to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequ Examine The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Physiclan/Medical IF FEMALE If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 → Yes 2 No 3 Probably 4 □Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s certificate 1□ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 □ Yes 2 교 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) After thi 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by 4 | Homicide 29a. Certifier 1 Defitifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division of Vital Records,

31. Date filed (Month, Day, Year)

MAR 0 7 2006

32. Jegistrar's Sign

WILLIAM ROBINS, M.D. 200 CIVIC AVE., SALISBURY, MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3. Time of Death

For	State of	r maryland	/ Depa	artment of Health and IV	ientai Hygie	ene		
State Registrar			Cei	rtificate of Death	Reg. No.			
Decedent's Name (First, Middle, Last)					2. Date of Death			
JAMES	L.	DAVIS	JR.		FEBRUARY	28	200	
Facility Name (If not institution, give s	treet and nur	nber)		4b. City, Town, or Location of Death		4c. Co	unty of I	

7350 VANDUSEN ROAD # 220 LAUREL, MARYLAND 20707 GITA SHAH M.D.

31. Date filed (Month, Day, Year)

MAR 0-3 2006

32. Registrar's Signature

Physician 06 1:30 P M /Medical 4a Death Examiner 707 60th AVENUE FAIRMONT HEIGHTS PRINCE GEORGE'S 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 9. Birthplace (State or Foreign **Funeral** Months Days 1 🕱 M 2 🗆 F Yrs. 578-96-9237 39 MARCH 11 1966 WASHINGTON, DC Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelith and Merital Hygiene. Important: if item 27 is marked other then "natural", or iteme 23a or 28a-1 show any injury or other traumatic event, the Madical Examiner reserves the page. 10c. City, Town or Location 10d Inside City Limits 10a State 10b. County 1 XYes 2 No Director PRINCE GEORGE"S FAIRMONT HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 707 60th AVENUE 20743 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2₹ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: BLACK ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE TIRE MECHANIC TECH. 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ETHEL M. DICKERSON JAMES L. DAVIS SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 707 60th AVENUE FAIRMONT HEIGHTS, MARYLAND 20743 19a. Informant's Name/Relationship (Type, Print) DIANA B. DAVIS/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State FT. LINCOLN CEMETERY 3/9/2006 SUITLAND, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Conteral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIO-RESPIRATORY FAILURE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner IMMUNE DEFICIENCY SYNDROME ACQUIRED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine ettending physicien and for use as the burial-transit The law requires thet the death certificate be executed RENAL FAILURE that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, CONGESTIVE HEART FAILURE Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the e 9☐ Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 3☐ No 24a. Was an autopsy performed? **≱**□ No certificete 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 \(\) Nursing Home 5 \(\) Residence 6\(\)Other (Specify) 1 ☐ Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA ဠ HOSPICE this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No i Director: / 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a
To the Funeral I
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier D20251 MARCH 1 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Pay 15, 2006 Physician Ralph K. 10:00a™ Dillon /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Renter

8 Ethesus

7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Jan. 2, Montgomery Bethesda Health Care Center 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1MM 2□ F Washington, D.C. 213-46-8977 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show Maryland Prince Georges Mt. Ranier 1X Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4205 32nd Street 20712 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status The Madical Examiners 1 ☐ Yes 2 No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black þ 3 ☐ Widowed 4 € Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled v Department of Health and Mental Hygien importents: if Item 27 is marked other it any injury or other traumatic event, ITE QRG: 10 Construction Worker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown Bessie Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12406 Appleby Ct. Upper Marlboro, Md. Theodore Proctor/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Feb. 25,2006 Suitland, Md. Lincoln Memorial 21. Signature of Funeral Service Lio 1000 22. Name and Address of Facility Pope Funeral Homes, P.A. 2617 Pennsylvania Av. S.E. Washington, D.C. 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Liver Cancer /Medical Due to (or as a consequence of): Examiner Inferior Vena Cava Clot Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner nding physicien and use as the burial-transit certificate be executed Hypertension Due to (or as a consequence of): Box 68760 Anemia Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant the atten 3 □Ectopic pregnancy 1 Live birth 2 Fetal death Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Nunknown Renal Insufficiency Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 🗌 Yes 1 🔲 Yes 2 X No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No P 2 EP/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title February 21, 2006 30. Name and address of pe who completed cause of death (Item 23a) (Type, Print) A av Pulmanily, 31. Date filed (Month, Day, Year) 6230 Democracy Blvd. Bethesda, Md. State Registrar DHMH 17 Rev 1/2001

ORIGINAL

2

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** February 25 2006 7:04 PM James Edward DuBard /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Temple Hills Prince George's 3502 Summit Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 X M 2 ☐ F Yrs 1938 North Carolina Director 67 15 243-52-2687 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f ehow traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Temple Hills Prince George's Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20748 3502 Summit Drive United States death v by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 TYYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Black Specify: 3 Widowed 4 Divorced *natural*, Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 Computer Scientist Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fit iment of Health and Mental H tant: If Item 27 is marked ott Estelle Simons Alphonso DuBard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3502 Summit Dr., Temple Hills, MD Robbie D. Cheers/Sister 20b. Place of Disposition (Name of Cares 1 in 1974) 20c. Location - City or Town, State 20a. Method of Disposition 5 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 3/5/2006 High Point, NC Gardens Cemetery 21. Signature of Funeral Service Licenspe 22. Name and Address of Facility Stewart Funeral Home (ewas 4001 Benning Rd., N.E. Wash., DC 20019 Approximate Interval Between Onset and Death Part1. Exter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock on heart failure. List only one cause on each line. Immediate Sause (Final disease or condition resulting in death) Physician Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of) Examiner Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed Hypertension and Due to (or as a consequence of): Box 68760. physicien Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death Check only one Hospital: Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 ANatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number MO 2 ens D25725 February 28, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cyrus Nemati, M.D. 3611 Branch Ave., Suite 407, Temple Hills, MD 20748 31. Date filed (Month, Day, Year) State MAR 0 1 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** MARCH 4:50 P M **ELAM** 2 2006 NANCY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY SILVER SPRING HOLY CROSS HOSPITAL 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** VIRGINIA 1 ☐ M 2 💢 F Months Days Hours 579-44-5964 Director 70 AÚG. 15. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b Counts or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 → No Funeral Director MD CHARLES HUGHESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 14128 BEVERLY DRIVE 20637 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 200No If Yes, Give Year or Dates: Items 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married 5 1 ☐ Yes 2 🛣 No Specify Specify: Completed by 3 Widowed 4 □ Divorced WHITE "natural". 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CREDIT MANAGER DISTRIBUTOR .. Pages 1 and 2 should be filed w tment of Health and Mental Hygie tant: If item 27 is marked other t jury or other traumatic event, ID I Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, CLAUDE L. DELANO CHARLOTTE B. DAWSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CATHY L. ROACH / DAUGHTER 37725 APACHE ROAD CHARLOTTE HALL, MD 20622 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. BETHANY BAP.CH.CEMTY, 03-06-2006 CALLAO, VIRGINIA 4 Donation 5 Other (Specify) 22. Name and Address of Facility BRINSFIELD-ECHOLS FUNL.HME.,P.A. 21. Signature of Funeral Service License MOO641 30195 THREE NOTCH RD. CHARLOTTE HALL, MD 20622 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS 12 HOURS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day ĕ in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? STROKE 1 Yes 2 No 3 Probably 4 ∭Unknown Completed CORONARY ARTERY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? 2□ No 1 Yes certificate 1 Yes 2 💢 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1 Inpatient 2XXER/Outpatient Certification: To 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined

The law requires that the death certificate be executed Box 68760, P.O. Records. Division of Vital Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D28656

MARCH 3, 2006

bb5

State Registrar

Medical

31. Date filed (Month, Day, Year)

3 Suicide

29a. Certifier

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Shooty Grore Rd. #208 Rockville MD 20050 32. Fegistrar's Signature

			For State Registrar	State of Maryla	•	artment of I			iene	б	0839	95		
			Decedent's Name (First, Middle, La	ist)				2. Date of Deat Month	h	Van	3. Time of E	Death		
Н	Physici /Medi		Lillian Foley	7				Februar	y 25, 2	006	6:00	Рм		
	Examir		4a. Facility Name (If not institution, giv Charlotte Hall V				or Location of Dea lotte Ha	11		of Death t. Ma	ary's			
	Funeral Director		086-18-9124	Gex 7. Age (In y. 1 ☐ M 2\sqrt{2}F 83	rs. last birthday) Yrs.	Months Days	If Under 24 Hrs Hours Min		Year) 1922	Coun	ace (State or try) W York	_		
	w w		Usuel Residence of Decedent 10a, State 10b, County	10c.	City, Town or Lo	ocation				10d. Inside City Limits				
	Ba-f sho	ctor	Maryland St. Mar	ry's		Charlott	e Hall				1 ☐ Yes			
	th with the	Funeral Director	10e. Street and Number 29449 Charlotte F	Hall Road; Room	n 2B205	10f. Zip Code	20622	1	0g. Citizen of W	S.A.	try?			
036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or liems 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: ₩W		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ₩o	Hispanic Origin? (San, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		- Americ k, White, (
21215-0036	n "natur Nedical	Completed	15. Decedent's E (Specify only highest gri	ducation ade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo	orking	16b. Kind of Bu	siness/Inc	lustry			
212	giene.	Com	12	College (1-401 5+)		Homemake	r		Own	Home				
Maryland	uld be filed Mental Hygisirked other tifc event, Ill	To Be (17. Father's Name (First, Middle, Last John A. Foley	r)				me (First, Middle, M ances Noc		Θ)				
	s 1 and 2 should if Heelth and Men item 27 is marks other traumatic		19a. Informant's Name/Relationship (ing Address (Street ickory La		lural Route Number LaPlata	-		^{Code)} 20646			
nore,	Pages 1 and ment of Heemant: if item		20a. Method of Disposition 1 □ Burial 2 ☑Cremation 3 □	_Hemovai irom State		osition (Name of matory or other pla	1 - 1		20c. Location -			nd		
Baltimore,	permit. Pages Department of Important: If i any njury or once.		4 □Donation 5 □ Other (Special 21. Signatur Finer Service Ligarity		2		ess of Facility J	ohn M. Ta	Brentwood, Maryland ylor Funeral Home Annapolis, MD 21401					
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	pplications that caused the do		-				Approximate Interval Between Onset and Death				
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a cons	equence of):	14100	le cen	ebral. Ovasc	Arten	1 W	lave	+		
		Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events	Due to (or as a cons	sequence of):						SEOS	e_		
oʻ	ate be executed hysicien and he burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Diabet Due to (or as a cons	es M sequence of):	ellip	15 0	idult	- Ons	et				
68760,	ficate be physicials to the bu		,	· hyper	ten	sim	,							
.O. Box	w requires that the death certificat been signed by the attending phy should be detached for use as th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of predictive birth 2 ☐ F 4☐ Pregnant at time of 9☐ Unknown	etal death 3[⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у		23d. Date Mor	e of delive	-	ear		
ds, P	The law requires that the ate has been signed by th page 2 should be detache	d by P	Part II. Other significant conditions	contributing to death but not in	resulting in the u	Inderlying cause gr	ven in Part I. MC4		pacco use contr es 2 □ No	ibute to th		_		
Records,	e la has	mplete	hypothy:	pidism	os	Hopo	nosis	24a. Was a autops perform	y p	Vere autor	osy findings a npletion of car	vailable use of		
al			O ement +	ia			00 Bloom of Do	1 ☐ Yes 2	2 1 No 1	Yes	2□ No			
Vital	e v ∺	To Be	examiner?	Hospital: 1 ☐ Inpatient 2	ER/Outpatie	nt 3□ DOA Ott	200	eath <i>(Check only on</i> Home 5 \to Reside		er (Snecifi	·)			
10	ding Phys h. After this funeral di		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year				28d. Describe ho			<i>,</i>			
Division of	or Attending after death. Director: After in by the fune	Certification:	1 Accident 5 Pending investigation 3 Suicide 6 Could not be determined	on OB OBS Blace of Injury A	t home, farm, st	M 1]Yes 2□No	28f. Location (St City or Town		er or Rura	l Route Numb	er,		
_	To the Hospital or Attent within 24 hours effer death To the Funeral Director: completely filled in by the	edical Ce	29a. Certifier 1 Certifying P (Check only one) 2 Madical Exa	hysician: To the best of my l minar: On the basis of exam and manner stated.	knowledge, deat ination and/or in	th occurred at the ti	me, date and plac opinion, death occ	e, and due to the caurred at the time, d	ause(s) and ma ate and place, a	nner as st and due to	ated. the cause(s)			
	To the within To the compl	Me	29b. Signature and title of certifier	sh.		29c. Licens	5092	2	9d. Date signed	(Month, I	Day, Year)			
,			30. Name and address of person	completed cause of death (tem 23a) (Type			ne Fre	1 100	10	(D)	5.1 =		
			31. Date filed (Month, Day, Year)	KOOK 32 Registrar's Sig	Die mature	le 20	Sini	nce pre	dnick		11) 2	0678		
	Sta Registr			nns separate	K A	south 1								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) 3 Time of Death February 26, 2006 **Physician** Ernestine Gregory 12:47 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X F Yrs. 237-22-9556 Director 84 Feb 1, 1922 North Carolina Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itsm 27 is marked other than "natural", or itsms 23a or 28a-f show other treumatic svent, the Maxical Examiner mast ke matified at 1 Yes 2 No Director Maryland | Prince George's Glenn Dale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5907 King Arthur Way 20769 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ho Specify: Specify: Black Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) llth Lab Technician Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental I 90 James E. Boyd Lillian Grier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Young (Daughter) 5907 King Arthur Way, Glenn Dale, MD 20769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 iment of It 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ Depertment important: if sny injury or once. 4 □ Donation 5 □ Other (Specify) 3/4/2006 Maryland National Laurel, MD 21. Signature Funeral Service Licenses 22. Name and Address of Facility Latimore Funeral Services, P.A. atricia Laterrore 6906 Kent Town Drive, Landover MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ventricular **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) been signed by the s should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2, ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No page 2 autopsy performed certificate 1 Yes 2 No Vital completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 R/Outpatient 3 DOA မှ this ŏ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Division Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge death occurred at the time, late and place and due to the nause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00057124 momo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13219 Executive Park Terrace, Germantown MD 20874 Truong Bao, M.D. 2. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 2 2006 Registrar

RNESTI NE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle Last) Month Day Vaar **Physician** Holly Gilhoolv Evelyn 1PM 27,2006 February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8712 Gunston Road Welcome Charles If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) If Under 1 Year Months Days 9. Birthplace (State or Foreign Country) ND 7. Age (In yrs. last birthday) 5. Social Security Number 216 - 48 - 9673 **Funeral** Months 1 □ M 2 🕱 F 98 Director December 25,1907 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 🙀 No MD Charles Completed by Funeral Director Welcome 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. To hours after death with to Important: if item 27 is marked other than "natural", or Itams 23a or 21 any injury or other traumatic event, the Medical Examination 2008. 8712 Gunston Road 20693 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 Never Married 2 Married Wildowed 4 Divorced Yes 2 2 X10 1 ☐ Yes 2 ☐ No Specify: Specify: white Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Albert Sorg Leona Breed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JoAnn Gilhooly/Daughter 8712 Gunston Road, Welcome, MD 20693 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State ' 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olive Methodist 3/7/06 Randallstown MD 21. Signature of Funeral Service Licensee M00945 2ARTHARTSECTIOLS FUNERAL HOME, P.A. P.O. BOX 567, LA PLATA, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Bronchitis disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav Year in the past 12 months? 1 ☐ Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by failure 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No advanced an. 1 ☐ Yes 2 ☐ No 1 🗀 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Residence 6 Other (Specify) Certification: To 28b. Time of 27. Manner of Death 28d. Describe how injury occurred

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

the Maryland

Baltimore, Maryland 21215-0036

28a-f show

traumatic evant, the Madical Examinar must be notified at

/Medical Examiner burial-transit attending physician for use as the burial the detached has or Attending Physician: ours after death. Ieral Diractor: After this certifica filled in by the funeral director. I within 24 hours a To the Funeral L

To the

State Registrar

ical

29b. Signature at

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

5 Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day Year) determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

havics St

28f. Location (Street and Number or Rural Route Number, City or Town, State)

The Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

and address of person who completed cause of death (Item 23a) (Type, Print) Letchtord MO

32. Projetrar's Signature 31. Date filed (Month, Day, Year)

MAR 0 6 2006

				State of Ma	aryland /			of Death	Mental Hy	/giene Reg. No.	08398
Ī	Physici		Decedent's Name (First, Middle, La. Mary Hay						2. Date of D Month Feb	Day	3. Time of Death Year 006 10:50pm
-	/Medic Examin		4a Facility Name (If not institution, giv					4b. City, Town, or			
1	LAGIIII	eı	Bradford Oak N	ursing H	ome			Clinto	n	PG	
	Funeral Director		5/8-32-34/2	ex 7. Ag ☐ M 2対 F 9	e (In yrs. last i 3		If Under 1 Y Months Da	ear If Under 24 Hrs ays Hours Min	8. Date of B (Month, D May 0	th ay, Year) 1,1912	9. Birthplace (State or Foreign Country) Virginia
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loca	tion				10d. Inside City Limits
	e Maryl	ctor	Md PG		Clin	ton					1 ☐ Yes 2 ☐ No
	₹ 2 €	Pie	10e. Street and Number				10f. Zip Co			10g. Citizen of V	Vhat Country?
	ath w	a	7706 Surrats R				2073			USA	
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinar must be notified at once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	40	10	Tes 2√2				e - American Indian, ck, White, etc. ··· Black
5-("natu	etec	15. Decedent's Ed (Specify only highest gra	lucation de co <i>mpleted)</i>	16	Sa. Deceder	nt's Usual O	ocupation one during most of wo otired)	orking	16b. Kind of Bu	usiness/Industry
12	withir ene.	dmo	Elementary/Secondary (0-12)	College (1-4or 5	+)			Speciali.		Federa	l Govt
d 2	filed Hygid Sther ent, I	S	17. Father's Name (First, Middle, Last)	4yrs	12.0	51 501	IIICI	-		e, Maiden Surnam	
<u>lan</u>	fental fental ked c	To Be	William Holmes					Mary	Saundei	cs	
ary	s mer		19a. Informant's Name/Relationship (Type, PrintGod	15	9b. Mailing	Address (St	reet and Number or F	lural Route Numi	ber, City or Town,	State, Zip Code)
Σ.	and 2 ealth n 27 I		Frances Gilles	pie(daug	hter 9	9425	Temp	le Hill			
ore	or oth	-1	20a. Method of Disposition 1 □ Burial 2 ♣ Cremation 3 □	Removal from State	ceme	tery, crema	ion (Name of tory or other	place)	Date		City or Town, State
tim	Factorial Page 1		4 ☐ Donation 5 ☐ Other (Specify	<i>(</i>)	Rive				03-4-06	River	dale Marylan
Bal	Depar Impor any In	-	21. Signature of Funeral Service Licer	Bell &				ddress of Facility J. Young	719 K	Washiı Cennedy	ngton DC 2001 St. NW
			23a. Part1. Enter the disease or com shock, or heart failure. List only	plications that caused	the death. Do	o not enter	the mode of	dying, such as cardia	c or respiratory	arrest,	Approximate Interval Between
	Physician /Medical Examiner	-	Immediate Cause (Final disease or condition resulting in death)	a Alzhe		s Di	seas				Onset and Death
	cuted nd ransit	edical Examiner	Sequentially list conditions,	b	Due to (or as	a conseque	ence of):				
68760,	tificate be executed g physician and as the burial-transit	ial Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C							
	certificate nding phys		resulting in death) Last	d	Due to (or as a	a conseque	nce of):				
m	d for u	iclai	Part II. Other significant conditions o	ontributing to death b	ut not reculting	s in the und	arlying cause	a given in Part I	23h Did	tobacco use co	ntribute to the cause of death?
9, P.O	v requires that the death cer been signed by the attendin should be detached for use	y Physiclan/M	Tat ii. Ottor algimoant conquiona o	onthibuting to death be	at not resulting	, in the una	onying cause	9,40,1111,411,1		Yes 2√2 No	3 ☐ Probably 4 ☐ Unknown
Division of Vital Records, P.O. Box	> 200	Completed by							24a. Wa perl	s an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?
E E	iician: The law certificate has b irector, page 2 s	Con							1 🗆	Yes 2 No	1 ☐ Yes 2 ☐ No
Ž Ž	cian: entific ector	Be	25. Was case referred to medical examiner?	Hospital:				Othor	ath (Check only		
of	Physi this c ral din	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpatie		Outpatient Time of	3□ DOA	4 gaj Nursing	-	idence 6 Oth	
CO	ding P. After funer	tlon	1 Natural 5 ☐ Pending	(Month, Day		Injury		njury at Work? 1□ Yes 2□ No	20d. Describe	now injury occur	60
Divisi	To the Hospital or Attending Physician: The law within 24 bours after death. To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined			farm, stree				(Street and Numb wn, State)	er or Rural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	edical C	20s Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of timer: On the basis of and manner sta	examination a	ge, death o and/or inves	courract at the	le time, date and plac ny opinion, death occ	e and due to the urred at the time	cause(s) and ha , date and place,	and due to the cause(s)
	within 2 To the	Me	29b. Signature and title of certifier	7			29c. Lic	ense number		29d. Date signe	d (Month, Day, Year)
	(3)		· Well)	Jun	0		D35	206	1	March 0	2,2006
	20		30. Name and address of person who					7	404	n	WD 005 44
	19 S		William Tanner 31. Date filed (Month, Day, Year)	MD. 1170	1 Liv	ings	con R	oad,Suit	e 101	rt.Wash	,MD 20744
	Sta Registr			A		marke.	,				
DH	MH 16 Rev 6/95		MAR 0 3 2098	A. S. S. C.	Jan Jal	A				-	·

DHMH 16 Rev 6/95

			For State Registrar		State o	f Ma	ryland				lealth Death		lental Hy	/gier		6	083	99
K	Physicia	ın	1. Decedent's Name (First, Middle										2. Date of D		l ą y	Year	3. Time o	f Death
	/Medic		JOSEPHINE S. HO 4a. Facility Name (If not institution,	-					41 07				Februa	1	0 0	1006	1 2:30	PM
	Examine	er	Doctors Commun:							nham	r Location	of Death			lc. County		rge's	
100	Funeral	200		6. Sex	nospi		(In yrs. la	ist birthday)	If Unde	r 1 Year	If Under		8. Date of B	irth			orge s	or Foreign
- 8	Director		579-18-1426	1 🗆 N	4 2⊠F	8	35	Yrs.	Months	Days	Hours	Min.	Dec. 2	а <i>у. Үөа</i> !3	1920	Wash	niny) .ingto:	a DC
	puq *		Usual Residence of Decedent 10a. State 10b. County				10c City	Town or Lo	ration								10d. Inside C	
	Aaryla f sho	5	,	0	,													2 No
	289-	rect	Maryland Prince 10e. Street and Number	Geo	rge's		Нуат	tsvil	Le 10f. Zig	Code				10g. C	Citizen of V	What Cou		
5	3a or		5602 Gallatin St	tree	t					781				-	S.A.		,	
na	n 72 hours after death with the Maryland "natural", or items 23a or 28e-f show cortal Examinat must be notified at	Funeral Director	11. Marital Status	12.	. Was Dece	edent E	ver in U.S	i. 13. V			ispanic Or	igin? (Sp	ecify Yes or N Rican, etc.)		14. Rac		can Indian,	
364	or ite		1 Never Married 2 Marrie	∌d	1 Yes Giv	2 ☑ No	0		☐ Yes		Specify:		rilouri, oto.)		Specify	ck, White, v:	etc.	
100	hours tural	Completed by	3 ₩ Widowed 4 Divorced	n Educati	Year or Da	ates:								1 401		Whi		
7.	in 72	ojete	15. Decedent (Specify only highest	grade c	completed)			16a. Deced (Give : life. L	kind of wo	rk done d	during mos	st of work	ing	160.	Kind of Bu	usiness/in	dustry	
212	d with giene. r ther	mo	Elementary/Secondary (0-12)		College (1	1-4or 5+	-)	Cle	rical		•			K	inlir	oer	Editor	~ c
ď	al Hyg	BeC	17. Father's Name (First, Middle, L	ast)							18. Moth	er's Nami	e (First, Middle				<u>Lu Leoi</u>	
, la	Mental Mental arked c	9	Joseph A. Spec	ht							Mar	у Т.	Rest					
ηe Maryland 21215-0036	2 sho and is mu		19a. Informant's Name/Relationsh	ір <i>(Туре,</i>	, Print)			19b. Mailin	g Address	(Street a	and Numb	er or Rur	al Route Numb	oer, City	or Town,	State, Zip	Code)	
	s 1 and 2 should be filed of Health and Mental Hyg item 27 is marked othe other traumatic event,		William A. Horma	ın Ji	r S	Son	20h Pla	2122 A	Avent	urin	e Way		Llver S					0904
cseph/			20a. Method of Disposition 1 □ Burial 2 ☑ Cremation		noval from	State	Cel	me <i>tery, cre</i> m	atory or o	other plac						,	own, State	
Joseph/ altimore,	ntmer rtant njury	Į	4 Donation 5 Other (Sp 21 Signature of Furgeral Service)	-			Metr	opolita				3/1/	2006 sch's F	Αlε	xand	ria,	Virgi	nia
Ba	permit. Page Department of Important: if any injury or once.		Allow The	der		40	134						ue, Hy					d 207
			23a. Part1. Enter the disease, or o	complica	tions that c	aused t	the death.										Approxima	te
	Physician		shock, or heart failure. List of Immediate Cause (Final	nry one				ACL	+11		716	. , 71	1 0 131	. 1			Interval Be Onset and	Death
	/Medical		disease or condition resulting in death)	a	Due to ((or as a	conseque	ence of):	/ / C	- 0	11/0	//	1010h	//			3 m	0
	Examiner		Sequentially list conditions	ь.		Pm	801	no VI	4								1 1000	
	p ti	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (20							- 10	
	and I-trans	xam	that initiated events resulting in death) Last	с.	Due to /	(01.35.2	GVV2 conseque	NL	E	tt	K S1 C	n					2 3	
8760,	sate be executed physicien and the burial-transit				200101	(0. 43 4	CONSEQUE	snoe or).										
9	Physician: The faw requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/Medical		d.														
Вох	that the death certificated by the attending p	Z	IF FEMALE: 23b. Was decedent pregnant	23c.	If yes, out										23d. Da	te of delive	ery	
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		1☐Live b 4☐Pregn 9☐Unkno	ant at ti			Ectopic pa Other (sp						Мо	nth	Day	Year
P.O	at the by the	hys	9 Unknown															
Division of Vital Records, P.O	igned be de	2	Part II. Other significant condition	is contril	buting to de	eath but	not resul	ting in the un	derlying o	ause give	en in Part I						ne cause of	
oro	w require been sig	eted											111	Yes	2 ∐ No	3 Prot	ably 4X	Jnknown
3ec	has t	Completed									 		24a. Was			Were auto prior to co death?	psy findings mpletion of c	available ause of
7	ysician: The is certificate hadirector, page												1 ☐ Yes	2 2 N		1 🗆 Yes	2□ No	
<u> </u>	sicia	00	25. Was case referred to medical examiner?	Hos	pital:	/		D/Outputing	200	Othe	20		Check only		. 570			
of	g Phys er this eral dir	D: 10	27. Manher of Death	- 1	28a. Date of	npatient of Injury		R/Outpatient 28b. Time of		8c. Injury Work	4 🗀 NU		me 5 Res 28d. Describe				y)	
Ö	Attending Indeath.	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga		(Mont	tn, Day	Year)	Injury	М		<br Yes 2□	No						
is Sis	after death Director: in by the	Certification:	3 Suicide 6 Could no 4 Homicide determin		28e. Place	of Injur	y - At hon (Specify)	ne, farm, stre	et, factor	, office			28f. Location (Street a	ind Numb	er or Rura	I Route Nun	nber,
0	itel or A	Ç																
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 Certifying (Check only 2 Medical E	Physici xaminer	r: On the ba	asis of e	examination	ledge, death on and/or inv	occurred estigation	at the tim	ne, date an pinion, dea	d place, th occurr	and due to the	cause(s) and ma	nner as s	tated.	s)
	thin 2 the omple	Med	one) 29b. Signature and title of certifier		and mann	ner state	ed.				e number						Day, Year)	
	()		,	h	1	-	,					5 10						
	6		30. Name and address of person w		pleted caus	e of do	ath (Item	23a) (Type 5	Print\	110	0 4	0 7	1 no, Riv		2/2	1/6	6	
1	20		Roger Inghan	1 /-	510	K	mil	unrth	H	1500	Str	24	O Rin	Pril	1/0	mr	20	737
	Stat	е	31. Date files (Month, Day, Year)	, 0	32. R	egistrar	's Signatu	Ire	, //6	-	200	- (/ 6	, 100	L 0 W/		1111	0	. 01
	Registra	ır	MAR 0 3 200	6	March			hard										

			For State Registrer	State of Mary		artment of			iene	08400
	Physici		Decedent's Name (First, Middle, L DOMINIC	ANTHONY	HARRISO			2. Date of Deal	th Day Year	3. Time of Death
	/Medio Examin Funeral		4a. Facility Name (If not institution, given 1300 Checkey) 5. Social Security Number 6.	ve street and number) 1 Berry Wes	y yrs. last birthday)	4b. City, Town	or Location of Death	1	4c. County of Death Prince Yeal 965 9. Birth Col	C 2525 splace (State or Foreign intry)
	Director		218-90-3497 Usual Residence of Decedent 10a. State 10b. County	40	Yrs.	ocation		DECEMBE	R 16 WASI	LINGTON, DC 10d. Inside City Limits
	e Maryla Be-f shor	Director	MD PRINCE	GEORGE'S		MARLBOR				1X Yes 2 □ No
	th with th		10e. Street and Number 7300 CHECKERBE	RRY WAY		10f. Zip Code 2077		1	0g. Citizen of What Co. U.S.A.	untry?
900	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f show the Medical Examirer must be mailfied at	by Funeral	11. Marital Status 1 ☐ Never Married 2 【 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	1	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2X N	f Hispanic Origin? (Suban, Mexican, Puerlo Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify: BI	
Maryland 21215-0036	filed within 72 h Hygiene. ther then "netu int, Ite Medica	Completed	15. Decedent's 1 (Specify only highest g Elementary/Secondary (0-12) 12th	Education rade completed) College (1-4or 5+)	(Give	dent's Usual Occ kind of work dor DO NOT use reti NTORY SE	ne during most of wor red)	rking	16b. Kind of Business/l	·
and 2	be filed tal Hyg ad othe event.	To Be C	17. Father's Name (First, Middle, Las EDWARD FREE					me (First, Middle, I	Maiden Sumame)	
Maryl	12 sh h and 7 Is m treum	Ĕ	19a. Informant's Name/Relationship KAREN D. HARR	(Type, Print)			et and Number or Ru	ıral Route Number	City or Town, State, Z	
	jes 1 an of Heal if Item 2 or other		20a. Method of Disposition 1 △ Burial 2 ☐ Cremation 3	☐Removal from State	Ob. Place of Dispo cemetery, crei	osition (Name of matory or other p	lace)	Date	20c. Location - City or	Fown, State
Baltimore,	permit. Page Department of Importent: If eny injury or once.		4 □ Donation 5 □ Other (Special Sign ture of Special rylice Lice		22	2. Name and Ado		. B. JENK	BRENTWOOD, CINS FUNERA CR, MARYLAN	L HOME
	Physician /Medical		23a. Part1. Enter the disease, or conshock, or heart failure. List onlimmediate Cause (Final disease or condition resulting in death)	y one cause on each line. a Gunsh	st W.		ying, such as cardia		est,	Approximate Interval Between Onset and Death
	Examiner	J.	Sequentially list conditions,	b. Due to (or as a cor						
68760,	tte be executed sysician and ne burial-transit	Ical Examiner	Sequentially list conditions, if any, loading to infine distered use. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a cor						
.O. Box	death certifica e attending ph od for use as tl	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3[□Ectopic pregnar □ Other (specify)			23d. Date of deli Month	very Day Year
s, P	signed d be de	by	Part II. Other significant conditions	contributing to death but no	t resulting in the u	nderlying cause	given in Part I.		bacco use contribute to	the cause of death?
al Record		Completed						24a. Was a autops perform	sy prior to d	topsy findings available completion of cause of
of Vital	Physiclen: Th this certificate ral director, pag	To Be	25. Was case referred to medical examinar? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient	2 ER/Outpaties	nt 3 DOA)ther	ath <i>(Check only on</i> Home 5 ☐ Reside	ne) ence 6 □Other (<i>Spe</i> c	city)
ion o	nding Ph ath. r: After th e funeral		27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Injury (Month, Day Yes		W	jury at /ork? □ Yes 2-10	28d. Describe h	in head	hst
Division	of or Attendation of the or Attendation of the ortor:	Certification:	3 Suicide 6 □ Could not 4 □ Homicide determine	be one Blace of Injury	At home, farm, st	reet, factory, office	се	Oily or Town	treet and Number or Ru n, State)	Chicari
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical C	29a. Certifier 1 Certifying F	Physician: To the best of my aminer: On the basis of exa and manner stated	/ knowledge, deat mination and/or in	h occurred at the	time, date and place y opinion, death occi	e, and due to the curred at the time, d	ause(s) and manner as late and place, and due	stated.
	To the within To the compl	Me	29b. Signature and title of certifier Alvoly	Shetwoo		29c. Lice	ense number	2.7	29d. Date signed (Month	7. Day, Year)
1	#1-6		30. Name and address of person who	o completed cause of death	(Item 23a) (Type,	Print)	ne, then	real r	Tebruary 1 Any land	,, 200
	Sta Registi		31. Date filed (Month, Day, Year) MAR 0 3 2006	32. Registrar's S	Signature	,		3)	· · ·	

			For State Registrar	State of Ma	rylan		artmen rtificat			nd M		jiene	006	08401
#	Physici		Decedent's Name (First, Middle, JOSEPH	F. HAR							2. Date of Dea Month FEBRUAR	th Day	Year 2006	3. Time of Death 10:07 A M
F	/Medic Examir		4a. Facility Name (If not institution, s	give street and number)				Town, or	Location of		FEDRUAR	4c. 0	County of Dea	
	Funeral Director	133				ast birthday) Yrs.	If Under Months		If Under 2 Hours	Min.	8. Date of Birth (Month, Day DECEMBE	Year) 9	9. Bir	thplace (State or Foreign ountry) TH CAROLINA
	e Maryland Be-f ehow	Director		GEORGE'S		y, Town or Lo		ΙΤ						10d. Inside City Limits 1X Yes 2 □ No
	with the	Dire	10e. Street and Number				10f. Zip				1		en of What C	ountry?
336	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23s or 28e-f ehow eumatic event, the Medical Exporter must be notified at	by Funerai	303 68th PLACE 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:					spanic Origi n, Mexican, Specify:	in? (Spe Puerto f	cify Yes or No- Rican, etc.)		4. Race - Am Black, Whi	erican Indian, te, etc. BLACK
Maryland 21215-0036	vithin 72 hounds.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education	-)	life. I	kind of wo DO NOT us	rk done d se retired)	uring most o	of workir	ng		d of Business	•
land 2	e filed al Hygi I other vent,	To Be Co	3rd 17. Father's Name (First, Middle, La UNKNOWN	ist)		SUP	ERVIS	SOR	18. Mother		(First, Middle, i		•	NT
	es 1 and 2 should b of Health and Ment: fitem 27 is marked r other treumatic a	-	19a. Informant's Name/Relationship CARLA JOANN HAR			19b. Mailir 303 6	g Address 8 th E	(Street a	nd Number SEAT	or Rura	ASANT,	City or	Town, State,	Zip Code) 20743
Baltimore,	permit. Pages t. Department of He Importent: If Item any injury or oth ORCE.		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		C	lace of Dispo emetery, cren MONY C	natory or o	ther place		o 4/2/			ation - City or	Town, State IARYLAND
Ball	permit Depart Import any inj		21. Signature of Funding Source Li	\rightarrow		7	474 I	ANDO	VER R	OAD	B. JENK LANDOVE	R, M		
	Physician /Medical Examiner	<u></u>	23a. Part1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. CONGES: Due to (or as a CARD IO) Due to (or as a Due to (or as a CARD IO)	o. CIVE consequ TYOP	HEART Jence of): ATHY			, such as ca	ardiac oi	r respiratory arr	est,		Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physicien and of for use as the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a										
O. Box b	at the death certific by the attending p tached for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □Live birth 2 4 □ Pregnant at the 9 □ Unknown	Fetal	death 3 [Ectopic pr Other (sp					23	d. Date of de Month	livery Day Year
rds, P	w requires that the been signed by th should be detache		Part II. Other significant condition:	s contributing to death but	not resu	ılting in the ur	nderlying c	ause give	n in Part I.					o the cause of death?
Vital Records,	The law ate has b page 2 st	Completed	RESPIRATORY F	AILURE						_	24a. Was a autops perform	У	death?	utopsy findings available completion of cause of 2 No
	Physician: Th this certificate ral director, pag	Be c	25. Was case referred to medical examiner?	Hospital:							(Check only on			
ion of	ding After	atlon: To	1 Yes 25 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigal	28a. Date of Injury (Month, Day		ER/Outpatien 28b. Time of Injury		Bc. Injury Work	4∐ Nurs at ? es 2 □ No	2	ne 5 Reside 8d. Describe ho			cify)
DIVISION	2 # # 2 €	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	building, etc.	(Specify	·) 					City or Town	, State)		ural Route Number,
	To the Hospitel within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Medical Ex	Physician: To the best of aminer: On the basis of and manner stat	examinat	vledge, death ion and/or inv	estigation,	in my opi	inion, death	place, a occurre	d at the time, da	ate and p	lace, and due	o to the cause(s)
	with To Con		· Ka	emm	The	np		License		23/	MO	od. Date	128	h, Day, Year)
T	200	to.	30. Name and address of person where REVATHY MURTH 31. Date filed (Month, Day, Year)		LANI	OOVER 1		CHEV	ERLY,	MAR	YLAND 2	0785		
	Sta Registr		MAR 0 3 2006	Elever A	4	perle	,							

		For Stete Registrar	State	of Marylar		artment of the rtificate of		nd Me	ntal Hy	giene Reg. No.	106	08402
		1. Decedent's Name (First, Middle	, Last)					2.	Date of Do	eath Day	Year	3. Time of Death
Physicia /Medica		JAMES BLAIR	HARDEN					P	IARCH	4	2006	2:14 AM
Examine		4a. Facility Name (If not institution	_			4b. City, Town,		Death			ounty of Deat	h
		BALTIMORE VA I		CENTER		BALTI I If Under 1 Year		Hrc o	D (D.		V/A	
Funeral		5. Sociat Security Number	6. Sex 1 ⊠ M 2 ☐ F	7. Age (In yrs. 84	Yrs.	Months Days		Min	. Date of Bi (Month, D une 3	av Year)	l Co	hplace (State or Foreign untry) nington, DC
Director		577.22.6249 Usual Residence of Decedent		04				J	une 5	, 192.	I wasi	ingcon, bo
yland yland	Ì	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
Man 1-1-sh	ţċ	Maryland Queen	Anne	C	hester							1X Yes 2 No
th with the Marylan 23a or 28e-1 ehow	Director	10e. Street and Number				10f. Zip Code				10g. Citize	on of What Co	untry?
23a g	18	45-A Queen Nev	a Court			21619				U.S		
	Funeral	11. Maritat Status 1 Never Married 2 Marr	Armed F	2 No 12	44	Was Decedent of I f Yes, specify Cub 1 ☐ Yes 2 🖾 No		n? (Specif Puerto Ric	y Yes or N can, etc.)		I. Race - Ame Black, White Specify: Whi	e, etc.
uref.	d b	3 ☑ Widowed 4 ☐ Divorced	Year or	Dates: 194	5		- 17					
N = 0	Completed	15. Decedent (Specify only highes)	16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	pation during most of	f working		16b. Kind	d of Business/	Industry
within then	dm	Elementary/Secondary (0-12)	College 2 Yea	(1-4or 5+)	1	ture Man				Fu	rniture	2
filed within 72 Hygiene. other then "natent, the Michigan		17. Father's Name (First, Middle,					18. Mother's		-	e, Maiden S	umame)	
d be entai	To Be	Louis Clement	Harden				Cathe	erine	Byr	nes		
Shoul nd Me mark	Ĕ	19a. Informant's Name/Relations			19b. Mailin	ng Address (Street	and Number of	or Rural F			Town, State, Z	Tip Code)
nd 2 sith as 27 io		Cynthia A. Har	den/Daugl	nter	45-A	Queen Ne	va Cour	ct, C	heste	er, MD	21619	
t Heart term	- 1	20a. Method of Disposition			Place of Dispo	sition (Name of matory or other pla	ica)	Date	0	20c. Loca	ation - City or	Town, State
Pan Pan Pan Pan Pan Pan Pan Pan Pan Pan		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		n State	*:	eaven Ce		3/08/	2006	Silve	r Spri	ng, Marylan
permit. Pages 1 and 2 should be filed within 7/2 Department of Health and Mental Hygines Important: If fleen 27 is marked other then "neny injury accepter fraumatic event, the Mental Const.	Ì	21. Signature of Funeral Service	icensee	+	HI	Name and Addr NES-RINA	ess of Facility LDI FUN	NERAL	HOMI	E, INC	Carin	g, MD 20904
Physician		23a. Part1. Enter the disea e, or shock, or heart List Immediate Cause (Final disease or condition		caused the dea each line.	th. Do not ent	er the mode of dy	ng, such as ca	urdiac or r	espiratory a	arrest,	SPILL	Approximate Interval Between Onset and Death
/Medical		resulting in death)	a	o (or as a consec								
Examiner		Sequentially list conditions,	b									
D =	ner	if any, teading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a consec	quence of):							
be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C									
cian cian surial		Tooling in down, and	Duste	o (or as a consec	querice or).							
icate be executed physician and s the burial-transit	dicai		d									
eath certific		IF FEMALE:	23c. If ves. of	utcome of pregn	ancv					22	d. Date of deli	
eath cattern for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐Live	birth 2 Fet	el death 3[Ectopic pregnand Other (specify)	у			23	Month	Day Year
at the de by the	yste	1 □ Yes 2 □ No 9 □ Unknown	9□ Unk			_ Cilioi (aposii)/ _						
that ned b		Part II. Other significent condition	ns contributing to	death but not re	sulting in the u	nderlying cause gi	ven in Part I.		23e. Did	tobacco use	e contribute to	the cause of death?
uires n sign	d by								1 🗆	Yes 2 🗆	No 3 □ Pr	obably 4 Unknown
w requir been si should	lete								24a. Wa	s an	24b. Were au	topsy findings available
he la e has	Completed								auto	opsy ormed?	prior to death?	completion of cause of
Ilicet or, po	ပိ	25. Was case referred to medical					26. Ptace of	f Death //	1 Yes	2 No	1 LI Yes	2 No
s cert	To B	examiner? 1 ☐ Yes 2 🗶 No		Inpatient 2	ER/Outpatie	t 3□ DOA Ot	bor				Other (Spec	cify)
		27. Manner of Death 1 X Natural 5 □ Pendin	28a. Date (Mo	e of Injury onth, Day Year)	28b. Time o Injury	f 28c. Inju	ry at ork?	286		how injury		
tend Jeath tor: /	cat	2 Accident investig	ot bo				Yes 2 No		Longtion	(Chront and	Alcombas os D	and Charles Market
or Al	Certification:	4 Homicide determ	ned 280. Plac	ding, etc. (Speci	ify)	eet, factory, office		201		own, State)	Number of Hu	ral Route Number,
ppital Durs a erel l		29a. Certifier 1 Certifyin	g Physicien: To th	a hast of my loa	owledge des	n occurred at the "	ime date and	nlace and	d due to the	Calleg(s) =	nd manner co	stated
24 hc 24 hc Fun etely 1	Medical	(Check only 2 Medical one)	Exeminer: On the	basis of examination of the state of the sta	ation and/or in	vestigation, in my	opinion, death	occurred	at the time	, date and p	olace, and due	to the cause(s)
ompli	Me	29b. Signature and title of certifie				29c. Licen	se number			29d. Date	signed (Monti	h, Day, Year)
- 3 - 0		V mue K.	Je M.D.			UMP	#: P19	840		MARC	H, 4, 2	.006
25		30. Name and address of person		use of death (Ite	m 23a) (Type,				NIF K			
Sta	te	31. Date filed (Month, Day, Year)	32.	Registrar's Sign					7,0 1	. 70140	1 1 1 1 1 1 1	/
Registra	ar	MAR 0	2006	Below -	15 19	300						

			1 — For State Registrer	State of	f Marylar		artmen <i>rtificat</i>			Mental Hyg	iene og. No.	06	0840)3
	Dhysia	.	1. Decedent's Name (First, Middle, L	.ast)						2. Date of Dear	th Day	Year	3. Time of	Death
	Physici /Medi		Furman Izza	ırd						February		2006	0110	DA M
j.	Examir	er	4a. Facility Name (If not institution, g	ive street and nun	nber)		4b. City,	Town, or	Location of Dea	ıth	4c. Cou	unty of Death		
			Holy Cross Hos						Silver S			Mon	tgomery	J
	Funeral			Sex 10XM 2□F	7. Age (In yrs.		If Under Months	1 Year Days	If Under 24 Hr Hours Mir	. (Month, Day,	Year)	9. Birth	place (State or ntry)	r Foreign
	Director		Usual Residence of Decedent		71	Yrs.				May 28,	1934	Sout	n Carol	lina
	land w		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside Cit	v Limits
	Mary	ò	M1 1 D				-						1 X Yes	
	28a	Je C	Maryland Prince 10e. Street and Number	: George'	S		10f. Zip		l Height		0a. Citizen	of What Cou	ntry?	
	3a o	2	1409 Eastern	Δνο					20743			ited S	•	
	death ms 2	Funeral Director	11. Marital Status	12. Was Dece	dent Ever in U	J.S. 13.	Was Deced	lent of Hi		Specify Yes or No- rto Rican, etc.)	14. 1	Race - Ameri	can Indian,	
9	or its	Ē	1 ☐ Never Married 2 X Married	Armed For	2 X No					rto Rican, etc.)		Black, White,		
පු	ours Fall.	d by	3 Widowed 4 Divorced	If Yes, Giv Year or Da	ates:		1□Yes 2	ZIXI NO	Specify:		Spe	ecify: B	Lack	
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show ta Madical Examinar canal be notilling at	Completed	15. Decedent's (Specify only highest of	Education trade completed)		16a. Dece (Give	kind of wor	k done a	luring most of wi	orking	16b. Kind o	f Business/In	dustry	
7	vithin ne.	mp	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT us							
7	lied v lygie ther i		9th 17. Father's Name (First, Middle, Las	-4)			Trans	sit (Operator		1:1 0	Priva	ate	
anc	ntal h	Be							18. Mother's Na	ame (First, Middle, I				
2	d Me d Me mark matk	ပို	Allen Izza 19a. Informant's Name/Relationship			10h Mailie	- Add	/Can - 4 -		Mamie				
₹	d 2 s th an 17 ls trau		Addie Mingo/Da							S.E. Wash.			(Code)	
စ်	Heal Heal tem 2		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nam	ne of	1			on - City or To	own State	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Madical Examiner count be notified at ΩΩςε.		1 Eurial 2 ☐ Cremation 3		otate	cemetery, crer	-		1					
ቜ	artme		4 □ Donation 5 □ Other (Special Signature of Fun@ral Service Lic		Ha:				Park 3/3	3/2006 Stewart Fu	Lar	ndover,	MD	
Ba	Dep Pen any		(ola) T	T 10.00	V 111	-				d., N.E.			20019	
			23a. Part1. Enter the disease, or co	mplications that ca	used the deat	th. Do not ent						, DC	Approximate	
	Dhusisian		shock, of heart failure. List on Immediate Cause (Final	y one cause on ea	ich line.			, .	,	, , , , , , , , , , , , , , , , , , , ,			Interval Betw Onset and D	veen
N	Physician /Medical		disease or condition resulting in death)	_ d	pirato: oras a conseq		est							
Н	Examiner						ive F)111ma	nary Di	Sease				
		ē	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying		or as a conseq			- CILIII	Juan y Di	beabe				
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	c										
Ó	be executed sician and burial-transit	Ĕ	resulting in death) Last	Due to (d	or as a conseq	juence of):								
8760,	requires that the death certificate be executed teen signed by the attending physician and hould be detached for use as the burial-transit	dical	•	d								-		
<u> </u>	ing pl	Med	IF FEMALE:								1			
Вох	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outo	ome of pregnanth 2 Feta		Ectopic pre	egnancy				Date of delive		
0.	e des the a	SIC	1 Yes 2 No	4□Pregna 9□Unkno	ant at time of d wn		Other (spe					Month	Day Ye	ear
<u>~</u>	res that the de igned by the a be detached f	된		anatributian ta da		- Min - In Min - I								
Š,	uires ti signe Id be c	Ď	Part II. Other significent conditions	contributing to dea	ain but not res	uiting in the ui	nderlying ca	iuse give	n in Part I.				ne cause of de	
0	w required should	Completed								1 L Ye	s 2 LING	3 Prob	ably 4 XU	nknown
ec	2 S	nple								24a. Was ar autops		b. Were auto	psy findings a mpletion of car	variable use of
<u> </u>		S								perform 1 ☐ Yes 2		death?	2□ No	
Žį.	slcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Unanital				1		ath Check only one)			
5	Physic this crain dir	မ	1 ☐ Yes 2 ☑ No			ER/Outpatien		-	4 Li Nutsing	Home 5 ☐ Reside	nce 6 🗆 0	Other (Specifi	v)	
ב	ding I	<u>S</u>	27. Magner of Death 1 ☐Natural 5 ☐ Pending		f Injury n, Day Year)	28b. Time of Injury		Bc. Injury Work		28d. Describe ho	w injury occ	curred		
Division of Vital Records,	r Attending Physicien: er death. rector: After this certific i by the funeral director.	Certification:	2 Accident investigate 3 Suicide 6 Could not	ho	-4 t-1 4. t-		М		es 2 □ No					
<u>></u>	를 를 를 다	Ħ	4 ☐ Homicide determine	28e. Place	of Injury - At he g, etc. (Specif	ome, farm, str y)	eet, factory,	office		28f. Location (Str City or Town	eet and Nu , State)	mber or Rura	I Route Numb	er,
_	Hospital or Attend 24 hours after death Funeral Director: / tely filled in by the f		29a. Certifier 1 T Certifying F	hysician: To the !	hact of my live	woden death		* * * * * * * * * * * * * * * * * * *	a date 1 d	. and division				
	- 07 - 10	edical	(Check only 2 Medical Exe	miner: On the ba	sis of examina	tion and/or inv	occurred a restigation,	in my op	e, date and plac inion, death occ	e, and due to the ca urred at the time, da	use(s) and ite and plac	manner as st e, and due to	ated. the cause(s)	
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	wing Health			29c.	License	number	29	d. Date sin	ned (Month,	Day, Year)	
)	- S + O		mul	Lesy										0.6
0	(0)		30. Name and address of person who	completed cause	of death /ltc=	n 23a\ /Tuna	Print1	Γ	32247		Feb	ruary	23, 20	06
	(8)		Nooshin Far		•	, , ,, ,	,	Road	C41770	r Spring,	MD	20910		
	Sta	te	31. Date filed (Month, Day, Year)	-	gistrar's Signa		GTEII	Noat	, ottoe	r obring	LID	20310		- r=
	Registr		MAD 0 1 200	S Minds	1	Chay	2							

		For State Registrar	State of Man			nt of Health te of Deatl		_	gien Reg. N		
, Physici		1. Decedent's Name (First, Middle, Last BEULAH PAULINE C		· -				2. Date of De Month MARCH	Da	2006	3. Time of Death 1
/Medic Examir		4a. Facility Name (If not institution, given MEMORIAL HOSPIT	e street and number)		,	Town, or Location	n of Death	runton	40	C. County of Dear	h
Funeral Director		5. Social Security Number 6. S 213-10-9738		n yrs. last birtho 86 yr	Months		Min.	8. Date of Bir (Month, Da 4-20-19	ay, Year	9. Bird Co PA	hplace (State or Foreigr buntry)
Maryland f ehow	or	Usuel Residence of Decedent 10a. State 10b. County MD ALLEGAN	Y	0c. City, Town o	or Location BURG						10d. Inside City Limits 1
3e or 28e-	i Direct	10e. Street and Number 414 PARK STREET				p Code .532			10g. C	itizen of What Co	puntry?
ING Z IZ IS-UUSO be filed within 72 hours after deeth with the Maryland tial Hyglene. dother than "naturel", or iteme 23e or 28e-1 ehow event, Ine Medical Examinari, maile incilitied at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1Yes 2No If Yes, Give Year or Dates:	er in U.S.	13. Was Dece If Yes, sp	dent of Hispanic Cocify Cuban, Mexic		ecify Yes or No Rican, etc.))-	14. Race - Ame Black, Whit Specify:	
A I Z I D-0000 of within 72 hours aft glene. or than "naturel", or the Medical Exerci-	ompleted	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)	(C)	ecedent's Usi Give kind of w fe. DO NOT	•	ost of work	ing		Kind of Business	Andustry
should be filed and Mental Hygin marked other imatic event, in	To Be Co	17. Father's Name (First, Middle, Last) PAUL CATHERMAN				18. Mot		e (First, Middle VE SHOP)		n Sumame)	
Z ~ Z = 7		19a. Informant's Name/Relationship (JAMIE JENKINS	Type, Print) SON			s (Street and Num KETREE T					
Dallimore, INI permit. Peges 1 and 2 Depertment of Health a Important: If Item 27 is eny injury or other tra onca.		20a. Method ol Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	20b. Place of D cemetery, FROSTBU	crematory or	other place) IORIAL PA		Date -15-06		ocation - City or STBURG	
Descrit. Depertit. Imports ony lnjk		21. Signature of Funeral Service Licer		0547		nd Address of Fac FUNERAL		E P.A.			N STREET MD 21532
Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart lailure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions	a. ASPIRATI Due to (or as a c	ON PNEU	MONIA	Ge of dying, such a					Approximate Interval Between Onset and Death
ificate-be executed g physician and as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a c								
death certif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 (4 □ Pregnant at tin 9 □ Unknown	Fetal death	3 ⊟Ectopic 5 □ Other (s					23d. Date of de Month	livery Day Year
2 2 2	ρ	Part II. Other significant conditions of	contributing to death but in	not resulting in t	ne underlying	cause given in Par	t I.				o the cause of death?
age age	Completed		J 1	<u> </u>				24a. Was auto perfe 1 Yes	psy ormed?	prior to death?	utopsy findings available completion of cause of 2 No
Physician: The This certificate ral director, pag	To Be	25. Was case relerred to medical examiner? 1 Yes 2 No	Hospital:	2 ER/Outp	atient 3 🗆 🗈	Othor		th (Check only)		6 ☐Other (Spe	ecify)
DIVISION OF VILA) I or Attending, Physician: 1 effer death. Director: After this certificat din by the funeral director, p		27. Manner of Death 1 Anatural 5 Pending 2 Accident Investigatio	28a. Date of Injury (Month, Day Y	(ear) 28b. Tin	ne of ury M	28c. Injury at Work? 1 ☐ Yes 2 [□No	28d. Describe	how inj	ury occurred	
DIVISION OI To the Hospital or Attending, Phys within 24 hours efter death. To the Funeral Director: After this completely filled in by the funeral di	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury building, etc. (n, street, facto	ry, office		28I. Location (City or To			ural Route Number,
he Hospital on 24 hours en he Funeral Detely filled i	ledical		nysician: To the best of a miner: On the basis of ea and manner state	camination and/							
To 11 To 11 Comp	¥	29b. Signature and title of certifier	O. Dans	ier (1) M()	D - 14	865			ate signed (Mont	
R		30. Name and address of person who DR.ROBUSTIANO BAR	/			SUITE 20)1 CIII			,	
Sta	ate	31. Date filed (Month, Day, Year)	32. degistrar		back)			. , , , ,		

Physician /Medical				nt in Black II court orde aryland / Dep Ce	ertificate of	Death		Reg. No.	08405
/Medical		Decedent's Name (First, Middle, Last					Date of De. Month	ath Day Yea	3. Time of Death
	L	Katherine	· L ,	JOHNS			March	3 200	
Examiner		4a. Facility Name (If not institution, give		1		or Location of Death		, 4c. County of De	
		Laural General 5. Social Security Number 6. S		l L je (In yrs. last birthda)	Laural // If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	Prince	
neral ector		578-7/1-06/10	☐ M 2 [XF	9.3 Yrs.	Months Days	Hours Min.	(Month, Da	y, Year) (irthplace (State or Foreign Country)
		Usual Residence of Decedent		93			nay Zi	1 1912 1	exas
rector		10a. State 10b. County		10c. City, Town or I	_ocation				10d. Inside City Limits
Director	2	D.C.		Washin	gton				1 ☐ Yes 2 No
P. C.	5	10e. Street and Number			10f. Zip Code			10g. Citizen of What 0	Country?
Funeral	2	1042 49th Str			2001			U.S.A	
nue	3	11. Marital Status	12. Was Decedent Amed Forces?		. Was Decedent of H If Yes, specify Cub	lispanic Origin? (Spec an, Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - An Black, Wh	
by		1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ∐Yes 2 🔀 If Yes, Give Year or Dates:	100	1 ☐ Yes 2X No	Specify:		Specify:]	Black
led	3	15. Decedent's Ed	ucation	16a. Dec	edent's Usual Occup	pation		16b. Kind of Busines	s/Industry
ple	2	(Specify only highest gra	de completed) , College (1-4or :	life.	e kind of work done DO NOT use retire	during most of workin d)			·
Completed	5		4 years		ntity Co	ntrol C1	erk	Federal (Government
Be (17. Father's Name (First, Middle, Last)		,	.,	18. Mother's Name		Maiden Sumame)	
၉	2	Newton Campl	e11	·		Mary I	rving		
T)C	J	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mai	ling Address (Street	and Number or Rural	Route Numbe	er, City or Town, State,	Zip Code) 20744
	-	Mary Campbell,	niece	910	Amer Dr	ive, Fort	Wash	ington,	Maryland
To	ì	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	200. Place of Disp	osition (Name of amatory or other pla	Da	ite	20c. Location - City o	r Town, State
	1	4 ☐ Donation 5 ☐ Other (Specify		Lincoln	Mem Cem	etery 3/	11/06	Suitland	d,Maryland
ons injury o		21. Signature of Funeral Service Licen	2600_	_	22. Name and Addre	ss of Facility HAL	L BRO	THERS FUN	NERAL HOME
a	1	1 Kuncy		6	21 Flori	da Avenu	e. NW	. Washing	gton DC
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused one cause on each li	I the death. Do not er ne.	nter the mode of dyir	ng, such as cardiac or	respiratory ar	rest,	Approximate Interval Between
n	- [Immediate Cause (Final disease or condition	a Myocar	dial Inf	arction				Onset and Death
il r		resulting in death)	Due to (or as	a consequence of):					
		Sequentially list conditions.	b. Hypert	ension					
ulne		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence on:		4			
Examin		that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
7									
oppo			d.						
Completed by Physician/Medic		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of de	plivery
cla		in the past 12 months? 1 ☐ Yes 2 ☑ No	1∐Live birth 4∐Pregnant at		□Ectopic pregnancy □ Other (s <i>pecify</i>)	'		Month	Day Year
hys	L	9 Unknown	9□ Unknown						
γP	F	Part II. Other significant conditions co	entributing to death b	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
pe		Crohns Disease					1 🗆 Y	′es 2 □ No 3 □ P	robably 4 🖫 Unknown
Set		G1aucoma					24a. Was a	an 24b. Were a	utopsy findings available
E							autop: perfor	sy prior to med? death?	completion of cause of
Be C		25. Was case referred to medical				26. Place of Death /	<u>, </u>	21	s 2 No
To B		examiner? 1 ☐ Yes 21 No	Hospital:	nt 2 X ER/Outpatie	nt 3 DOA Oth			lence 6 ☐ Other (Spe	acutu)
		27. Manner of Death	28a. Date of Inju	v 28b. Time o				ow injury occurred	s criy)
atio		1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		(injury		Yes 2 □No			
		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju	ury - At home, farm, si	reet, factory, office	28	f. Location (S City or Tow	Street and Number or F	Rural Route Number,
뜵			building, on	o. (Opcomy)			Ony of Town	m, State)	
Certific	- 1	29a. Certifier 1 X Certifying Phy	vsician: To the best	of my knowledge, dea	th occurred at the tin	ne, date and place, an	d due to the c	cause(s) and manner a date and place, and du	s stated.
cal Certification:			and manner sta	ited.			rattne time, c	ate and place, and du	e to the cause(s)
		57.07							
Medical Certific		one) 29b. Signature and title of certifier		1	29c. Licens		2	29d. Date signed (Mon	th, Day, Year)
Medical Certific		57.07	Lund)	was		22966		2/2/21	
Completely filled in by the Medical Certific		29b. Signature and title of certifier 7 7 80. Name and address of person who c			D 2	22966		2/2/21	
		29b. Signature and title of certifier 7 7 80. Name and address of person who c	WERES	eath (Item 23a) (Type	D 2	22966		3/2/06	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State
Registrar Amend# 11. Per Informant PGC 3-13-06 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death February 22 2006 0920 Michael Jones 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Prince George's 4702 Riverdale Road Riverdale Park If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1 X M 2 ☐ F 56 Vrs March 23 1949 Washington, DC 577-66-7167 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1X Yes 2 □ No Prince George's Riverdale Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4702 Riverdale Road #B 20737 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 20 Married 1 ☐ Yes 2 X No Specify: Specify: Black 3 ☐ Widowed → Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Rusiness/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bricklayer Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Unknown Doris Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tanya Jones/ sister 2109 Alice Ave. apt. #4 Oxon Hill, MD 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBuria/ 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) Fort Lincoln Ceme. March1,2006 Brentwood, MD 21. Sign of Funeral Service License 22. Name and Address of FacilityJohnson and Jenkins Funeral Home 716 Kennedy St. NW Washington, DC 20011 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) aATHEROSCLEROTIC CARDIOVASCULAR HEART DISEASE Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4☐ Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funerai

ģ

Completed

Be 2 10a. State

MD

Funeral

Director

show

28a-f

or Itams 23a or

netural,

Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other treumetic event

other t

hours after

Baltimore, Maryland 21215-0036

Box 68760

P.O.

other treumetic event, the Medical Exercit er must be notified at

burial-transi

Examine Physician/Medical þ Completed Be 2 Certification: Medical

29a. Certifier

29b. Signature and title of certifier

certificate be as the l ō the detached signed by Division of Vital Records, certificate has Hospitel or Attending Physicien: this After death. Director: after within 24 hours a To the Funerel C

State Registrar

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2X No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 📉 Residence 6 ☐ Other (Specify) 1X Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 Yes 2 No 2 Accident 3 🗍 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 - Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

25 31. Date filed (Month, Day, Yeaf)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

MAR 0 2 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

-			For State Registrar	State of M	laryland / D		ent of F		and Me		giene Reg. No.	006	08407
	Dhuaisi		1. Decedent's Name (First, Middle, Las	_					2	Date of Dea			3. Time of Death
	Physicia /Medic	al	Barbara 4a. Facility Name (If not institution, give	L.	Jenkins	4h	City, Town, o	er Location o	of Death	02	2.2	County of Death	1,20 AM
	Examin	er	Belour Heal	Many	Dall	6.	Bel	Air				+ARF	ORD
	Funeral		5. Social Security Number 6. Se 578-50-4600	7. A □M 21€ F	nge (In yrs. last birt 69	hday) If L Yrs. Mor	nder 1 Year ths Days	If Under a	Min. M	Date of Birt (Month, Date ay 18	h y. Year) 1936	9. Birthr Cou	place (State or Foreign htry) Lngton, DC
	Director		Usual Residence of Decedent							<u>u</u> , 10	1750		Od. Inside City Limits
	farytan ehow	or	10a. State 10b. County Harford		10c. City, Town								1X Yes 2 □ No
	r 28e-f	Irect	10e. Street and Number		liber		f. Zip Code				10g. Citiz	zen of What Cou	ntry?
	ath witi	by Funeral Director	201 Mayberry Dr.		II C	10.14 5	21001		sin2 /Consi	fu Vac or No		SA 14. Race · Americ	can Indian
(0	fter de	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceden Armed Forces 1 ☐ Yes 25	5?				gin? (Speci i, Puerto Ri	fy Yes or No can, etc.)		Black, White,	etc.
0036	ural', o	d by	3 ☑ Widowed 4 □ Divorced	ff Yes, Give Year or Dates			es 25 No	Specify:				Specify: B	lack
21215-0036	in "nat	plete	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)			(Give kind o	Usual Occup of work done OT use retired	during most	t of working	7	TOD. KII	IQ OI DUSINESSIN	dustry
213	led with	Be Completed	17. Father's Name (First, Middle, Last)	Zyrs		Admin	istrat			ant First, Middle,	Maiden	Govern	nent
land	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or iteme 23a or 28e-1 ehow aumatic event, it a Medical Examination with the notified at	To Be	Jackson Willis					Ma		. Moor			
Maryland	es 1 and 2 should b of Health and Ment fitem 27 is marked r other traumatice		19a. Informant's Name/Relationship (7			-	,					Town, State, Zip	Code)
	1 and Health tem 27		Maurice Jenkins/ 20a. Method of Disposition	5011	20b. Place of	Disposition	(Name of		Dai	on, DC		oation - City or To	own, State
Ō	Pages nent of B int: If ite		1 🖾 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		e	n Memo		Cem M					Maryland
Baltimore,	permit. Pages 1 Department of H Important: If ite ony injury or ot		21. Signature of Funeral Service Licen	SOO DE	Row							ins Fune DC 2001	eral Home
Kins 6 8760,	Physician Medical Examiner Medical Examiner Physician and Physician an	dicat Examiner	23a. Part1. Enter the disease, or compands, or heart failure. List only of mediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a	is a consequence of	al of):	Rend	g, such as	1	SEAS			Approximate Interval Between Onset and Death
Jen O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 3 No 9 □ Unknown		2 Fetal death at time of death		pic pregnance or (specify)	у			2	23d. Date of deliv Month	ery Day Year
S,	res that the signed by be detact	by Pł	Part II. Dther significant conditions of	ontributing to death	but not resulting in	the underly	ing cause giv	ven in Part I.	•				he cause of death?
17 ecord	w require been si should I	eted	Advance	ea v	emen!	19				1 🗆 1			
$\mathcal{Z}_{\mathbf{\pi}}$	The law ate has page 2:	Completed								autor perfo	osy rmed?	prior to co death? 1 \(\text{Yes}	opsy findings available impletion of cause of
/ital		Be C	25. Was case referred to medicat examiner?	Hospitaf:			0#			Check only o	ne)	1	
£ 5	Phys this ral din	n: To	1 Yes 2 No	1 ☐ fnpa 28a. Date of in (Month, D	tient 2 ER/Ou jury 28b. T	ime of	28c. Inju			e 5 Resid d. Describe		G □Other (Special Occurred	(y)
\mathcal{O}_{loi}	Attending or death.	atlo	1/□Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be			njury M	1 🗆	Yes 2 🗌					
Division	or Att efter de Direct J in by 1	Certification:	3 Suicide 6 Could not be determined	286. Place of I	njury - At home, fa etc. (Specify)	rm, street, fa	ictory, office		28	City or Tou	Street and wn, State)	d Number or Rur.)	al Route Number,
_	To the Hospitel or Al within 24 hours efter of To the Funeral Direc completely filled in by	edical C	29a. Certifier (Check only one)	ysician: To the bes niner: On the basis and manner:	of examination and								
	To the within To the comple	Me	29b. Signature and title of certifier	1000/			29c. Licens	se number			29d. Date	e signed (Month,	Day, Year)
	(2)		30. Name and address of person who	YVV	death (from 22c)	Type Bring	V	195	83	7	Feb	rugry	22, 2006
CR	- (3)		Manuel M	· 62	atin 1	12	3	4	W	> Vee	phil	proel	deen
	Sta Registi		31. Ďate filed (Month, Day, Year) MAR 0 2 200		strar's Signature	forte							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Viola Jeter 2000 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1□M 2€ F 251-44-0313 12/25/23 Jonesville.S.C Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1¥ Yes 2 No Md. P.G. Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5117 Duel Place 20743 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) P.G. Co. Board Elementary/Secondary (0-12) 6th College (1-4or 5+) Cafeteria Worker of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Silas Rice Faye (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard Jeter, Jr. / Husband 5117 Duel Pl. Capitol Heights Md. 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Ft. Lincoln Cem. 3/6/06 Brentwood, Md. Name and Address of Facility Sons Co., Inc. 21. Signature of Funeral Service Licensee 4925 Burroughs Ave., N.E., Wash., D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 WULK Due 10 (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 1 Live birth 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 Tyes 2 □No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ō

dical Examiner must be notified at

Director

Completed by Funeral

Be

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death v Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "nature" any injury or other treumatic every

attending physicien and for use as the burial-transit use as the ed by the a detached f s been signed by the should be detach page 2 s certificete this After thi death. Director: / within 24 hours after To the Funeral Direct

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 No 1 Yes 25. Was case referred to examiner?
1 \(\text{Yes} \) Yes \(2 \text{No} \) Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28c. fnjury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Tyes 2 □No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)



State Registrar

Name and a

31. Date filed (Month, Day, Year) MAR 0 2 2006



mpleted cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Jack 6:52A M termany 23 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Doctor's Community Hospital Prince Georges Lanham If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1**√** M 2□ F 247-72-8072 62 Yrs July 21, 1943 South Carolina Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Director Maryland Prince Georges Bladensburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5800 Annapolis Rd. 20710 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1[™] Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) 8th College (1-4or 5+) Private Truck Driver 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H lant: If item 27 is marked other. Be Colin King Joyce McDonald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5800 Annapolis Rd. Bladensburg, Md. Tawanda Evans /Daughter or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 3/1/2006 Brentwood, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23 Yers Mariboro Pike/Forestville, Mg. A. 20747 0108 23a. Part1 Enter the disease, or complication is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one reuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Unknown End Stage Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-fransit The law requires that the death certificate be executed Due to (or as a consequence of): by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 □Ectopic pregnancy Day 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 2 🗀 No 2 **X**No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣No 1 X Inpatient 2 2 ER/Outpatient 3 DOA this After the funeral of 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Reista Fah 2/23/06 1243443 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REINTAN FARAHIFAR M.O 9801 Georges Are suit 3-41 Silver Sprigh D 20902 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Elecu & Specie Registrar

Baltimore, Maryland 21215-0036

Records, P.O.

Division of Vital

			State of Maryland / Department of Health and State of Maryland / Department of Health and Certificate of Death		giene Reg, No. 1 1 6	08410
9	Physicia	20	Decedent's Name (First, Middle, Last)	2. Date of Dea Month	Day Year	3. Time of Death
	/Medic	al	Carlton Roy Kurka 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea	March	5 2006 4c. County of Deat	7 P M
	Examin	er	Atlantic General Hospital Berlin		Worceste	r
25	Funeral Director		5. Social Security Number 6. Sex 1XD M 2D F 85 Yrs. 6. Sex Months Days Hours Mir		9. Birt (Co.	hplace (State or Foreign untry) Florida
	yland how		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits XXYes 2 □ No
	8a-f e	octor	MD Worcester Ocean City		10g. Citizen of What Co	
	h with th	ai Dire	2401 Philadelphia Ave. 10f. Zip Code 21842		US	uriuy:
980	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other then "natural", or iteme 23a or 28a-f ehow	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puerly Cuban, Puerly Cuban, Mexican, Puerly Cuban, Puerly Cu	Specify Yes or No arto Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours f Health and Mental Hygiene. Item 27 is marked other then "natural", other traumatic event, the Modical Ext	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)	orking	16b. Kind of Business	'Industry
2	Hygier Hygier ther ti	CO	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	ame (First, Middle,	Maiden Sumame)	
ane	lid be lental rked o	To Be		ne Hutte	nlocker	
ary	0. 00 = 5		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Relationship (Type, Print)			
ره ح	ss 1 and 2 of Health litem 27 l		Detty Kurka (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	ve., Ocea	an City, Md 20c. Location - City or	
Baltimore,			4 Donation 5 Other (Specify) Sunset Memorial Park 3-		Berlin, Md	
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility T 108 William St.,			Home
	Physician		26a. Part1. Enter the disease, or complications that caused the Gard. Do not enter the mode of dying, such as cardi shock, or hear failure. List only one cause on each line. Immediate Cause (Final Allers Ler Air Cardiovis culture)			Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
	B =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
×	ficate be executed physician and is the burial-transit	Examiner	Cause (Disease or riflury that initiated events resulting in death) Last Due to (or as a consequence of):			
5- 0x 68760,	cate be physician the buri	edicai E	d			
3 - 5 0x 68	nding use as	lan/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1		23d. Date of de	livery Day Year
10-0 -0.B	0 0 D	Physicia	in the past 12 months? 1 Yes 2 No 9 Unknown Other (specify)		Worth	buy rou.
0.6 2xp./*	The law requires that the tte has been signed by the bage 2 should be detache	b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		tobacco use contribute t Yes 2 🗆 No 3 🗆 P	o the cause of death? robably 4 Inknown
0.0 - Recor		Completed		24a. Was auto perfe 1 \(\text{Yes}	psy prior to death?	utopsy findings available completion of cause of
1/201 (34) Vital	ysiclan: Th is certificate director, pag	Be	examiner?	eath Check only		
of of	Physic r this o	To To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		idence 6 Other (Spe how injury occurred	ecify)
5	Attending Physician: in death. sctor: After this certific: by the funeral director.	atior	2 Accident investigation M 1 Yes 2 No			
Kwrka, Jul	il or Attendate deat	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location City or To	(Street and Number or R wn, State)	lural Route Number,
Ž.	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one) Cartifying Physician: To the best of my knowledge, death occurred at the time, date and playone medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and playone medical examiners of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and playone medical examiners of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and playone medical examiners.	ace, and due to the courred at the time	cause(s) and manner a , date and place, and du	s stated. e to the cause(s)
	To th within To th compl	Me	29b. Signature Inchingor certifier 29c. License number D2876	9	29d. Date signed (Mon	th, Day, Year)
ET	1+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Notice Dorschule, who 1209 Coastal Hyling, T	Ewick	Tilud, De	19944
*	St. Regist	ate rar	31. Date filed (Month, Day, Year) (32. Restrar's Signature MAR 0 7 2006			

			For State Registrar		State of	of Maryl		partment o <i>ertificate d</i>		d Men	tal Hygier Reg. 1	2006	08411
			Decedent's Name (First	t, Middle, Las	t)		· ·				ate of Death		3. Time of Death
	Physici /Medio		DAVID LERM	NER							bruary	28, 2000	6 8:18 ^{а м}
	Examin		4e. Fecility Name (If not in	stitution, give	street and nu	ımber)	-	4b. City, Tow	n, or Location of D	Death		4c. County of De	ath
			Holy Cross	s Hosp	ital				r Spring			Montgom	
	Funeral		5. Social Security Number		ex Min 2□F		yrs. last birthda	Months Da		Min. (/	ate of Birth Month, Day, Yea	ar) 9. B	irthplace (State or Foreign Country)
	Director		212-68-6625 Usual Residence of Decer			8	3 Yrs.			De	c. 20,	1917 Nev	W York City
	land			County		10c	City, Town or	Location		-			10d. Inside City Limits
	Mary	ō	Maryland Mon	ntgome	rv	т.	akoma E	Park					1 ☑ Yes 2 ☐ No
	the	Director	10e. Street and Number	i e gome			aroma 1	10f. Zip Coo	е		10g.	Citizen of What 0	Country?
	3a o		1208 Elson	Place				2091	2			U.S.A.	
	deati	Funeral	11. Marital Status		12. Was Dec	edent Ever	n U.S. 1	3. Was Decedent	of Hispanic Origin Juban, Mexican, P	? (Specify	Yes or No-	14. Race - An	
ဖွ	after or tte		1 Never Married 2	. ☐ Married		2 X No		1 ☐ Yes 2⊠		dello rical	1, 610./	Black, Wh	nte, etc.
8	within 72 hours after death with the Maryland ene. then "neturel", or iteme 23e or 28e-f ehow he Medical Examiter must be notified at	d by	3 ☑ Widowed 4 □ D	ivorced	Year or E	Dates:			то ороспу.			1	White
21215-0036	net	Completed	15. D (Specify only	ecedent's Ed ly highest gra	ucation de <i>completed)</i>)	16a. De	cedent's Usual Oc ive kind of work do a. DO NOT use re	cupation ne during most of	working	16b.	. Kind of Busines	s/Industry
2	withir ane. then	μ̈	Elementary/Secondary	(0-12)	College ((1-4or 5+)		ales	ill ed)			Real Est	tato
0 0	filed Hygi ther ant,	ပို	17. Father's Name (First, I	Middle, Last)	·				18. Mother's	Name (First	st, Middle, Maid		cacc
a	Id be ental ked c	To Be	Abraham I	Lerner					Jenn	ie Pr	aeger		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelih and Mental Hygiene. Important: if item 27 ie marked other then "neturel", or iteme 23s or 28s-f ehow any injury or other treumatic event, the Madical Examiner must be notified at ance.	-	19a. Informant's Name/Re	elationship (7	ype, Print)		19b. Ma	ailing Address (Str	eet and Number o	or Rural Ro	ute Number, Cit	y or Town, State	, Zip Code)
Ž	alth a		Sharon J. Ba	aker -	Daught	er	P.O.	Box 603	Presto	n. Ma	rvland	21655	
Je G	of He trem		20a. Method of Disposition	n		20	b. Place of Dis	sposition (Name o		Date	20c.	Location - City of	or Town, State
Ē	Page nent c int: if		1 ☐ Burial 2 ☑ Crer 4 ☐ Donarion 5 ☐ C			State		itan Crem		/02/2	006 A1	exandria	a, Virginia
Baltimore,	mit. pertn ports y injv	9	21. Signature of Funeral	Sylvin Licen	s 00				dress of Facility				
<u> </u>	89 5 8		Hen L.	which		-		4739 Bal	timore A	venue	, Hyatt	sville,	Maryland 207
			23a. Part1. Enter the dise	ease, or confi re. List only	dications that one cause on	caused the o	leath. Do not	enter the mode of	dying, such as car	rdiac or res	piratory arrest,		Approximate Interval Between
E	Pnysician	8 7	tmmediate Cause (Final dis 4 se or condition		a Arr	ythmi	a						Onset and Death
	/Medical Examiner		resulting in death)		Due to	(or as a con	sequence of):						
ı	ZAGITITIO	ē	Sequentially list condition	ns,	b. Con	gesti	ve Hear	t Failur	е				
	ted	nine	if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	4		` '							
	al-tra	Examin	that initiated events resulting in death) Last	- 1		nal Fa:	sequence of):						-
8760,	ficate be executed physicien and s the burial-transit	dicai		·	d								
Θ	tificat ig phy as the	ledi											
ŏ	h cer endin use	N/	IF FEMALE: 23b. Was decedent pregr	nant	23c. If yes, ou	utcome of pre		3 DEctopic pregna	NOCY			23d. Date of d	
Division of Vital Records, P.O. Box	that the death certif ed by the ettending detached for use as	Physician/Me	in the past 12 month 1 Yes 2 No	ns?		nant at time		5 Other (specif)				Month	Day Year
G.	at the d by the etach	Phy	9 Unknown										
Ś	uires tha signed I Id be det	þ	Part II. Other significant					, ,	•		23e. Did tobacc		to the cause of death?
oro	w requir been si should	ted	Hypothyroi	iaism	rieura	T CII	usion,	Aliasarca		-	1 105		Probably 4 Unknown
ec	e law hes b	Completed								-	24a. Was an autopsy	prior to	autopsy findings available completion of cause of
<u> </u>	: The l										performed 1 ☐ Yes 2 2 2		s 2□No
\frac{1}{2}	ysician: his certific director.	Be	25. Was case referred to examiner?		Hospital: 32				Other		eck only one)		
ō	Phys ral di	.T	1 Yes 2 No 27. Manner of Death		Hospital: 1 28a. Date		2 LEP/Outpa 28b. Time	tient 3 DOA	4 📋 Nursii		5 Residence Describe how in	6 □Other (Sp	pecify)
O	ding Phy th. After thi funeral o	ţ		Pending investigation	(Mor	nth, Day Yea			njury at Work? I∐Yes 2 ☐ No			,,,	
/isi	Attend r death octor: by the	fica	3 Suicide 6	Could not be	28e. Plac	e of Injury -	At home, farm,	street, factory, off	ce	28f. L	ocation (Street	and Number or	Rural Route Number,
á	ellor Seffe Dir Dir	Certification:	4 Homicide		build	ding, etc. (Sp	ecity)			(City or Town, St	ate)	
	To the Mospital or Attending Physician: The law requires that the death certifi within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the ettending completely filled in by the funeral director. page 2 should be detached for use as	cai (29a. Certifier 1덫 0	Certifying Ph	ysician: To the	e best of my	knowledge, de	eath occurred at the	e time, date and p	place, and o	tue to the cause	e(s) and manner	as stated. ue to the cause(s)
	the H lin 24 the F plete	ledical	one)		and mar	nner stated.				occurred at			
		Σ	29b. Signature and title of	f certifier					ense number			Date signed (Mo.	
	9	- 8		orgi	~	-		الرا	00551	48		1128/3	2006
	LO		30. Name and address of	/	completed cau	ise of death	(Item 23a) (Ty	oe, Print)		CII		, _	206.5
	Sta	to	31. Date filed (Month, Day		32	Registrar's S	ignature	101637	GIEN Kd	. 2111	er >pri	19. 14.0	20110
	Registi			0 3 200	6 Ke	50.52	# A	sole					20410
				W W CUU		-							

		State	of Maryland	/ Depa		ealth and M	lental Hyg	iene	086.12
Physic		Registrar 1. Decedent's Name (First, Middle, Last)		Cer	uncate of t	Jean	2. Date of Deat Month	h Day Year	3. Time of Death
Physic /Med Exam	ical	Geraldine Ellington La 4a. Facility Name (If not institution, give street and			4b. City, Town, or	Location of Death	March 1	L, 2006 4c. County of Death	4:00 PM
	10 K.	Summerville at Woodwar		n t frieth day)	Bowie	If Under 24 Hrs.	8. Date of Birth	Prince Ge	
Funera Directo		5. Social Security Number 5.8 ex 1 M 2XX	7. Age (In yrs. las	Yrs.	Months Days	Hours Min.	(Month, Day, 01/23/1	Year) Con 1912 Vir	nplace (State or Foreign untry) ginia
Maryland -f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Georg		Town or Lo	cation				10d. fnside City Limits 1 X Yes 2 □ No
vith the	Director	10e. Street and Number			10f. Zip Code			0g. Citizen of What Col	untry?
peritinities in the profile A. I.A. 13-0030 pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 I e marked other than "natural", or Items 23e or 28e-f show any injury or other treumatic event, Ire Madical Examirar must be notified at	Funeral	1 Never Married 2 Married 1 Yes	Decedent Ever in U.S. 1 Forces? es 2 (2)No , Give		20785 Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Spo n, Mexican, Puerto Specify:		JSA 14. Race - Amer Black, White Specify:	
hours tural;	ed by	3 Widowed 4 □ Divorced Year 15. Decedent's Education	or Dates:	16a. Dece	dent's Usual Occup	ation		Whi	
Maryiaria 4 14 15-0030 nd 2 should be filed within 72 hours aft lith and Mental Hygiene. 27 le marked other then "natural", or rtreumatic event, ire Madical Exem	Completed by	(Specify only highest grade complet	ed) ge (1-4or 5+)	(Give lite. i	kind of work done of DO NOT use retired Maker	during most of work	ing	Own Home	,
e filed at Hygie other i	Be Co	17. Father's Name (First, Middle, Last)		nome	Makel	18. Mother's Name	(First, Middle, M		,
y ical	To	Louis Ellington		10b Mailie	Address (Canada	Elizabet		City of Town State 7	in Coda)
IMAI nd 2 sh alth and 27 le m		19a. fnformant's Name/Relationship (Type, Print) Stephen W. Lawrence/ S	Son			and Number of Hura 11 Drive		; City or Town, State, Z MD 20715	ip Code)
mit. Pages 1 ar mit. Pages 1 ar partment of Hea portent: If Item? y Injury or other		20a. Method of Disposition 1 ☐ Burial 2 [XCremation 3 ☐ Removal fr 4 ☐ Donation 5 ☐ Other (Specify)	OIII State		sition (Name of matory or other place	1		20c. Location - City or Maldorf, MD	
Demit. Department imports		21. Signature of Funeral Septice Licensee		22	2. Name and Addres	ss of Facility Rob	ert E. I	Evans Funer e, MD 20715	al Home
Physician / Medica Examine be executed Examine bhysicien and sthe burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Acute 10 (or as a conseque 10 (or as a conseque Atheros 10 (or as a conseque	ence of): V System of): Sclen	Artery	Inta: Disea heart	se. Disea	ise	Interval Between Onset and Death Minute
death certif	Physician/Medi	in the past 12 months?	, outcome of pregnand ve birth 2 Fetal or regnant at time of dea nknown	death 3	Ectopic pregnancy			23d. Date of deli Month	very Day Year
law requires that the es been signed by the 2 should be detached.	þ	Part If. Other significant conditions contributing Chyonic You	to death but not result	4	4	1.	23e. Did tol	bacco use contribute to es 2 ₩NO 3 Pro	the cause of death?
The The ate h	Completed	Dementia	V		V		24a. Was a autops perform 1 ☐ Yes	med? prior to death?	topsy findings available completion of cause of 2 No
OI VILGI F Physician: Th rithis certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{PNo} \) Hospital:	I ☐ Inpatient 2 ☐ E	R/Outpatier	oth 30 DOA Oth	26. Place of Deat		ence 5XOther (Spec	Assisted
Attending Physic death. ector: After this by the funeral di	—	27. Manner of Death 28a. D		28b. Time o Injury	28c. fnjun Wor			ow injury occurred	"" LIVING
LIVISION I or Attending after death. I Director: Afte	Certification;		lace of Injury - At homulating, etc. (Specify)		reet, factory, office		28f. Location (Si City or Town	treet and Number or Ru n, State)	ral Route Number,
Hospita 4 hours Funerel ely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To Medical Examiner: On the and the control of the certifying Physician: To the certification Physician: To the certificat	o the best of my know ne basis of examination	rledge, deati on and/or in	h occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the cared at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
To the I wit in 2 To the I corr plet	Me	29b. Signature and title of partition	on	M.D	29c. Licens	2254	9	19d. Date signed (Month	n, Day, Year) 2, 2, 006
		30. Name and address of person who completed M. DIN 31. Date filed (Month, Day, Year)	cause of death (Item 2	23а) (Туре, е и Й 1ге	Print) Worth	Ive, R.	verda	le Mayle	2, 2, 006 and 2, 073)
Regis	tate trar	MAR 0 3 2006	day &	1	and .				

		1 - State Registrar		artment of Health and Natificate of Death	Reg.	711116	08413
Physici /Medio	cal	Decedent's Name (First, Middle, Last) Helen Leonhard Aa. Facility Name (If not institution, give street in the content of the c	and number)	4b. City, Town, or Location of Death	Feb. 2	Day Year 4 2006 4c. County of Death	3. Time of Death 6:15 P M
Examir	ner	Heritage Harbour Hea	th Center 7. Age (In yrs. last birthday)	Annapolis If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	Anne Arur	place (State or Foreign
Director		156−26−7866	89 Yrs.	ocation	July 17,	1916 New	Jersey 10d. Inside City Limits
death with the Maryland ms 23a or 28e-f show fraust be neitified at	Director	MD Anne Arunde	Gambri	10f. Zip Code	10g.	Citizen of What Cou	1 □ Yes 2 No
be filed within 72 hours after death with the Marylan Ital Hygiene. od other than "neturel", or Items 23a or 28e-f show event, the Medical Examinar mant be natified at	by Funeral D	1 Never Married 2 Married 1 If	Is Decedent Ever in U.S. 13. ned Forces?	21054 Was Decedent of Hispanic Origin? (Srif Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	USA 14. Race - Americ Black, White, Specify:	etc.
within 72 hou lene. then "neture the Medical E	Completed	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12)	pleted) 16a. Dece (Give life.	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	king 16t	. Kind of Business/In	nite dustry
should be filed within and Mental Hygiene. • marked other than urmetic event, Ira Ma	To Be Co	12 17. Father's Name (First, Middle, Last) Roy E. Babcock	BOOM		e (First, Middle, Maid Ckerson	Hospital den Sumame)	
s 1 and 2 s if Health ar item 27 Is other treu		19a. Informant's Name/Relationship (Type, Pr. Sarah Leonhard / daug 20a. Method of Disposition 1 □ Burial 2 ▼Cremation 3 □ Remova	ghter 3508 20b. Place of Dispo	ng Address (Street and Number or Run Patuxent Preserve Desition (Name of Malary or other place)	Lane Ga	ty or Town, State, Zip mbrills, M . Location - City or To	D. 21054
permit. Page Department o Importent: If eny injury or once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Metropolit	can Crematory 03/0 2. Name and Address of Facility Be 5512 NW Crain Hwy.	all Funer	al Home	550
Physician /Medical Examiner		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final disease or condition resulting in death)	se on each line.	ter the mode of dying, such as cardiac		ease	Approximate Interval Between Onset and Death
cate be executed physician and the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):				
death certifi e attending I d for use as	hysician/Me	in the past 12 moons?		⊒Ectopic pregnancy □ Other (specify)		23d. Date of deliver	ery Day Year
The law requires that the te has been signed by the bage 2 should be detache	by P	Part II. Other significant conditions contribution	ng to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobaco	co use contribute to the	he cause of death?
The la ate has page 2	e Completed	OF Was associated to Miles			24a. Was an autopsy performed 1 Yes 2	prior to co death?	psy findings available mpletion of cause of 2 No
ding Phys h. After this funeral di	ertification; To Be	1 Natural 5 Pending 2 Accident Investigation	l: 1	nt 3 DOA Other: 4 Nursing Ho	th (Check only one) ome 5 Residence 28d. Describe how in	e 6 ☐Other (Specification)	y)
To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Director:	O	4 LJ Homicide	. Place of Injury - At home, farm, str building, etc. (Specify)		City or Town, S		
the Hosy thin 24 ho the Fune	Medicai	(Check only 2 Medical Examiner: O	To the best of my knowledge, death in the basis of examination and/or in dimanner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occur	red at the time, date	and place, and due to	the cause(s)
T W T 8		30. Number and address of person who complete	od cause of death (from 22a) (Time	1341978	2	Date signed (Month,	.006
Sta	ate	31. Date filed (Month, Day, Year)	4000 M Cd. Registrar's Signature	Zillalle Rd A31	2 Bowle	2 M) 2	0716.
Registr		MAR 0 2 2006	lie & span				

			For State Registrar	State of	Marylan				ealth a D <i>eath</i>	and M	ental Hy	giene Reg. No.		6	08414	,
			1. Decedent's Name (First, Middle, La	ist)	,						2. Date of Do	eath Day	, \	ear (3. Time of Death	
	Physicia /Medic		Marguerite M.	Laddbusl	ı						Februa			006	4:00 a	Ŋ
	Examin		4a. Facility Name (If not institution, gir	e street and nun	iber)		4b. City	, Town, or	Location of	of Death		4c.	County of	Death		
			Shady Grove Adve	ntist H	spital		R	ockvi	lle					Mont	gomery	
	Funeral				7. Age (In yrs.	last birthday	If Unde	or 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D Nov • 3	rth av. Year)		Birthp Coun	lace (State or Foreig	gn
	Director		578-24-2846	1□M 2🖺 F		80 Yrs.		Jujo			Nov. 3	80, 1	925	Wash	ington, [C
	pr ,		Usual Residence of Decedent		100 0	ty. Town or L	contion							1	0d. Inside City Limit	e
	anyla shov	_	10a. State 10b. County											1	1 ☐ Yes 2 🖾 N	
	Ba-f	cto	Maryland Montgon	nery	Ro	ckvil										
	ith th	Director	10e. Street and Number				10f. Z	ip Code				10g. Cit	izen of Wh		try :	
	ath w 23s		15309 Diamond (т		K		2085			2 12 14			SA	and the diam	
36	should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other than "netural", or liems 23a or 28a-f show marked other than "netural", or liems 23a or 28a-f show marked other than "netural".	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Amed Fo	2 1 No e	l.S. 13	Was Dec If Yes, sp	ecify Cuba	ispanic Ori in, Mexicar Specify:	gin? (Spe i, Puerto	ecity Yes or N Rican, etc.)	0-	14. Race Black, Specify:	White,	etc.	
Š	hour ural	d b	15. Decedent's E	Year or Da		16a Doc	edent's Us	ual Occup	ation			16h K	ind of Bus	iness/Inc	dustry	_
ς c	n 72	Completed	(Specify only highest g	ade completed)		(Giv	b kind of w	ork done d	during mos	t of worki	ng	100.11			,	
7	within 72 ene. than "ne.	Ē	Elementary/Secondary (0-12)	College (1	-4or 5+)		okkee					AF	LCIO			
7 7	Hygi ther int, I		17. Father's Name (First, Middle, Las	t)					18. Mothe	er's Name	(First, Middle	e, Maiden	Sumame)		
a	ould be filed v Mental Hygie harked other i hatic evant, II	o Be	Daniel Mullane						Anit	a Oa	tes					
Maryland 21215-0036	mari mati	은	19a. Informant's Name/Relationship	(Type, Print)		19b. Mai	ing Addre	ss (Street	and Numbe	er or Rura	al Route Numi	ber, City o	or Town, S	tate, Zip	Code)	
<u>∞</u>	d 2 s		Diane M. Laddbus		ter	1530	Dia	mond	Cove	Terr	racë, E	Rockv	ille	, MD	20850	
ā,	Hee Hee	1	20a. Method of Disposition		20b. I	Place of Disp	osition (N	ame of	na) .	_	Date	20c. L	ocation - C	ity or To	wn, State	_
٥	Se il so		1 ABurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			cemetery, cri te of H				arch 200		Silv	er S	orin	g,Marylan	ıđ
altimore,	Tangar a		21. Signature of Funeral Service Lice				2. Name	and Addres	ss_of Facili	ty _					J	_
Ba	permit. Pages 1 and 2 should be Department of Heelth and Menta Important: If Iem 27 is marked any nijury or other traumatic womes.		Nucharil I Hal	0		F:	ranci 00 Un	s J. ivers	Coll:	ins Blvd	Funeral	l Hom	Spr	ing,	MD 20901	-
	Physician / Medical busicien and physicien a	Examiner	23a. Part 1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to b. Due to c.	or as a consector as	quence of):	1		hage						Interval Between Onset and Death	
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physicien: The law requires that the death certificate I within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the attending physis completely filled in by the funeral director, page 2 should be deteched for use as the	by Physician/Medical	IF FEMALE: 23b. Was decellent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4□Pregn 9□Unkn	irth 2 ☐ Feta ant at time of a own	al death 3 death 5	□Ectopic □ Other (specify)			23a Did		23d. Date Mont	th	ory Day Year	
ŝ	res th	þ	Part II. Other significant conditions	contributing to di	ath but not re	sulling in the	undenying	cause giv	en in rail i	•	1	\			ably 4 Unknow	٧n
5	w requires to been signer should be control of the	ted														
Rec	nysicien: The law his certificete has b i director, page 2 s	Completed									24a. Wa aut per 1 \(\text{Yes}	opsy formed?	de pr	or to co	psy findings availab mpletion of cause o 2 No	f
/ite	cien. sertific actor,	Be	25. Was case referred to medical examiner?	Hospital:				Oth Oth	AC.		h (Check only					_
\leq	Physic this c al dire	은	1 ☐ Yes 2 No	1/9/		ER/Outpati		JOA	4 🗆 141		me 5 Re				y)	
C	Miter t	6	27. anner of Death 1 Natural 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time Injury		28c. Injur Wor	k?		28d. Describe	a now inju	ry occurre	d		
<u>s</u>	eath. tor: A	cat	2 Accident investigate 3 Suicide 6 Could not	he -			М		Yes 2	No	201 1	/C+	- d Maranta a	0	(Co. 40 At 100 Co.	
Ž	or At fter d Direct in by	Certification:	4 Homicide determine	A 208. Flace	of Injury - At I ng, etc. (Spec	iome, tarm, : ify)	street, fact	ory, office				own, Stat		r or Hura	al Route Number,	
	To the Hospital or Attending Ph Within 24 hours effer death. To the Funeral Director: After thi completely filled in by the funeral	Medical Ce	29a. Certifier 1 Certifying I (Check only one)	Physician: To the aminer: On the b	best of my kn asis of examin	owledge, de ation and/or	ath occurre	d at the tir	ne, date ai	nd place, ath occur	and due to th	e cause(s e, date an	i) and mar d place, a	ner as s	tated. the cause(s)	
	thin 2 ths mple	Mec	29b. Signature and title of certifier				2	9c. Licens	e number			29d. Da	ate signed	(Month,	Dey, Year)	
) AN	10				62	76	3		7	11 =	1/04	5	
	10		30. Name and address of person wh	o completed on	se of death /li-	m 23a) /Tu-	Print\	05	20.				10	1		
			30. Name and address of person with Horkim MOR	SLI MI	9901	Medi	call	ente	r DI	ive	Rock	Vill	2 MD	2	0830	
1	Sta Regist	ate	31. Date filed (Month, Day, Year) MAR () 6	2006	egistrar's Sign	ature	and the	P								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 7:00 A M **Physician** March 13, 2006 Evelyn Rae Matthews /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner Parkton Baltimore 18800 Cooper Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Sept. 2, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F 1925 218-22-1582 80 Yre Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County or 28a-1 ehow other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No MD Baltimore Parkton Completed by Funeral Director the 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code 18800 Cooper Road 21120 U.S.A. or Itams 23a filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If them 27 is marked other than "na any injury or other traumatic averagence." College (1-4or 5+) Elementary/Secondary (0-12) Canning Factory Factory Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Walter Wolfe Lillian Rae Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Michael R. Matthews, Son 2712 W. Ruhl Rd., Freeland, MD 21053 20b. Place of Disposition (Name of cometery, cromatory or other place)
Pine Grove United 20c. Location - City or Town, State Data 20a. Method of Disposition March 17, 1 X Burial 2 Cremation 3 Removal from State Parkton, MD * 4 □ Donation 5 □ Other (Specify) 2006 Methodist Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 4.7 24 Second St., New Freedom, PA 17349 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2744 /Medical **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant. 3 Ectopic pregnancy Day in the past 12 month Month 2 should be detached for 4☐Pregnant at time of death 5 Other (specify) P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records. 3 ☐ Probably 4 🐧 Únknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 1 Yes 25. Was case referred to me examiner? 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home Hospital: 1 Tyes 1 🗌 Inpatient 2 ER/Outpatient 3□ DQA 5 Residence 6 Other (Specify) Certification: To 27. Manper of Death, 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) In by 1 4 - Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 30 Name and addre cause of 32/ State Registrar

ysician Medical 4a. Facility Name (If not institution, give street and number) Vniversity of Mary land Medical Center Social Security Number 578-64-8667 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Month MARCH 05 2006 1:26 A 4c. County of Death 4c. County of De		For State Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	2. Date of Dea		3. Time of Death
Turners to Mary and Medical Courter Sold mark Supplement Country		James R. Miller				1:26 A
S. Scored Security Municipal Control (Control Control	University of Maryland Medical Center	Baltimore				
168. State 160. County 100. County 1	•	5. Social Security Number 6. Sex 7. Age (In yrs. last bin 1 ≥ 578-64-8667 1 ≥ 1 ≤ 1 ≤ 56	thday) If Under 1 Year If Under 1 Year Amonths Days Hours	Min. (Month, Day	y, Year) 9. Birt 49 Wast	hplace (State or Foreignintry) nington, DC
Continue of Alvin Priller Son 19b. Mailing Address (Street and Number or Peuts Reach, Maryland 20732 19b. Mailing Address (Street and Number or Peuts Reach, Maryland 20732 19b. Mailing Address (Street and Number or Peuts Reach, Maryland 20732 19b. Mailing Address (Street and Number or Peuts Reach, Maryland 20732 19b. Mailing Address (Street and Number or Peuts Reach, Maryland 20732 19b. Maryland 207			n or Location			10d. Inside City Limit
Continue of Alvin Priller Son 19b. Mailing Address (Street and Number or Peuts Reach, Maryland 20732 19b. Mailing Address (Street and Number or Peuts Reach, Maryland 20732 19b. Mailing Address (Street and Number or Peuts Reach, Maryland 20732 19b. Mailing Address (Street and Number or Peuts Reach, Maryland 20732 19b. Mailing Address (Street and Number or Peuts Reach, Maryland 20732 19b. Maryland 207	ctor					1 ☐ Yes 2√13/N
Continue of Alvin Priller Son 19b. Mailing Address (Street and Number or Peuts Reach, Maryland 20732 19b. Mailing Address (Street and Number or Peuts Reach, Maryland 20732 19b. Mailing Address (Street and Number or Peuts Reach, Maryland 20732 19b. Mailing Address (Street and Number or Peuts Reach, Maryland 20732 19b. Mailing Address (Street and Number or Peuts Reach, Maryland 20732 19b. Maryland 207	ai Dire					ountry?
Description of Alvin Priller Son 19b. Mailing Address (Sireal and Number or Plant Product Number, City or Fown, State, Zip Code) 19b. Mailing Address (Sireal and Number or Plant Product Number, City or Fown, State, Zip Code) 19b. Mailing Address (Sireal and Number or Plant Product Number, City or Fown, State, Zip Code) 19b. Mailing Address (Sireal and Number or Plant Product Number, City or Fown, State, Zip Code) 19b. Mailing Address (Sireal and Number or Plant Product Number, City or Fown, State, Zip Code) 19b. Mailing Address (Sireal and Number or Plant Product Number, City or Fown, State, Zip Code) 19b. Mailing Address (Sireal and Number or Plant Product Number, City or Fown, State, Zip Code) 19b. Mailing Address (Sireal and Number or Plant Product Number, City or Fown, State, Zip Code) 19b. Mailing Address (Sireal and Number or Plant Product Number, City or Fown, State, Zip Code) 19b. Mailing Address (Sireal and Number or Plant Product Number, City or Fown, State, Zip Code) 19b. Mailing Address (Sireal and Number or Plant Product Number, City or Fown, State, Zip Code) 19b. Mailing Address (Sireal and Number or Plant Product Number, City or Fown, State, Zip Code) 19b. Mailing Address (Sireal and Number or Plant Product Number, City or Fown, State, Zip Code) 19b. Mailing Address (Sireal and Number or Plant Product Number, City or Fown, State, Zip Code) 19b. Mailing Address (Sireal and Number or Plant Product Number, City or Fown, State, Zip Code) 19b. Mailing Address (Sireal and Road Chesapeake Beach Road Chesapeake Beac	þ	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes ₹⊠No If Yes Give			Black, White	e, etc.
Security Control Alvan March Control Alvan March Control Alvan March Control Alvan March Control Alvan C	eted		Decedent's Usual Occupation (Give kind of work done during mos	st of working	16b. Kind of Business/	Industry
Page Page	dwc				Construction	1
Source Continued Alvan Parlier Parlier			18. Moth			
Bursal 2 & Coremato 3 Removal from State 4 Donator 5 Clother (Specify)						7:- O- d-1
1. Bursal 2 & Common 3 Removal from State 4 Denoting 5 Other (specify) 2 Denoting 5 Other (specify) 2 Denoting 5 Other (specify) 2 Denoting 5 Other (specify) 3 Denoting 5 Denoting 5 Denoting 5 Denoting 5 Denoting 5 Denoting 5 Denoting 5 Denoting 5 Denoting 5 Denoting 5 Denoting 5 Denoting 6 Denotin			•			
23.2 Page Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, infavral Blowern Onset and Death disease or conditions cause (in each of the cause of the cause of the cause of death of the cause of the cause of death of the cause of		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 20b. Place of cemete. Kalas	Disposition (Name of y, crematory or other place)	Date	20c. Location - City or	Town, State
232 Page Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, infavral Blowern Onset and Death Infavral Blowern Onset and	- Silica	21. Signature of Funeral Service Licensee	22. Name and Address of Facil	George P. Ka Road Oxon Hill,	las Funeral Ho Maryland 2072	ome PA
Immediate Cause (Final disease or condition resulting in death) Beginning in death) Beginning in death) Beginning in death) Beginning in death in the past 12 months? In the past 12 months In the past 12 months? In the past 12 months In the past 12 months? In the past 12 months In the past 12 months In the past 12 months In the past 12 months In the past 12 months? In the past 12 months In the past 12 m	*	23a Pagh. Enter the disease or complications that caused the death. Do shock, or heart failure. List only one cause on each line.				Approximate Interval Between
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Enter Underl		disease or condition a. Hortic Uissection				31100; 4110 5040
FFEMALE: 23b. Was decedent pregnant 1 1 2 Fetal death 3 Ectopic pregnancy 1 1 4 Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant at time of death 5 Pregnant 4		Due to (or as a consequence	of):			
Due to (or as a consequence of): The past 12 months	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	of):			
FFEMALE: 23b. Was case referred to medical symmetric? 1 Natural 2 Secretarior 1 Natural 3 Secretarior 23c. If yes, outcome of pregnancy in the past 12 months? 1 Yes 2 No 3 Probably 4 Month Day Year 1 Y		resulting in death) Last Due to (or as a consequence d.	of):			
William than Hollan TV MD P15977 March 05 2006		23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No ☐ History 1 ☐ History 25c. If yes, ductions of pregnant of interpretation of pregnant of interpretation of pregnant of interpretation.				•
Without ambour MD P15977 March 05 2006		Part II. Other significant conditions contributing to death but not resulting i	n the underlying cause given in Part			
March 05 2006	ompiete			autor perio	osy prior to death?	completion of cause of
March 05 2006	O	evaminer?				
March 05 2006	2	1 Yes 2 No Hospital: 1 Inpatient 2 Floring 27. Manner of Death 1 Natural 5 Pending 1 No Natural 5 Pending 1 Inpatient 2 Floring 28a. Date of Injury (Month, Day Year) 28b.	Time of linjury at Work?	28d. Describe I		ecify)
Withhitamilton Halten TI MD P15977 March 05 2006	ertificat	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, for		28f. Location (ural Route Number,
Without am to the ten to MD P15977 March 05 2006		(Check only 2 Medical Examiner: On the basis of examination ar				
P15977 March 05 2006	dica		29c License number	r		th, Day, Year)
	Medical	29b. Signature and little of certifier	230. 230,130 114,150			

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Physician 7:06 am 02 06 /Medical MC 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner ntu 5. Social Security Number olumbia neral MD ou a Ho word If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 F 578-18-110 Usual Residence of Decedent -18-110 6 Yrs. Director 920. Virginia Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location or 28a-f show other traumatic avant, the Madical Exercitiver must be notified at 1 √Yes 2 No Director Maryland Prince George's College Park 10g. Citizen of What Country? 10f. Zip Code 7308 Radcliffe Drive 20740 U.S.A. tems 23a Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ttems 23 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Flementary/Secondary (0-12) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Harry Neal Marie Scism ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nancy L. Herring - Daughter 7308 Radcliffe Drive, College Park, Maryland 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ Department of Important: If any injury or QDCe. Fort Lincoln Cemetery 03/02/2006 Brentwood, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euroral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, Maryland 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** nes monia /Medical Due to (or as a consequence of) Examiner ettus Pleural Sequentially list conditions, if any, leading to immediate cause. Enter Undern in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transit To tha Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. as the l IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year o in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Diractor: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗀 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To tha Funeral 6 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1000 43 65 February 27, 2006 10 lug 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 57 Columbia, Maryland 21044 hawn 55 Ceda Evans ane 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrai MAR 03 2006

and Mental Hygiene nnc nal. 18

MARVIN C.	MARSHALL	State of Maryland / Department of Health
	For State Registrer	Certificate of Death

		,	1 - State Registrer		Cer	tificate of L	Death		Reg. No.	10	00410	
	- X		1. Decedent's Name (First, Middle, L.	ast)			<u>-</u> <u>-</u> .	2. Date of D	eath		3. Time of Death	
	Physici /Medic		Marvin C. Mar	shall				Februa	ry 22, 20	06 Year	6:43 P M	
	Examir		4a. Facility Name (If not institution, gi			4b. City, Town, or	Location of De		_	ty of Death		
			4701 B Rookewood Pla	æ		Waldorf			Charle	s		
	Funeral		Social Security Number 6.	Sex 7. Age (In yrs. I	last birthday)	If Under 1 Year If Under 24 Hrs. 8. Date 6 Months Days Hours Min. (Mont			rth av. Year)	Cor	nplace (State or Foreign	
	Director		217-02-8907	1⊠M 2□F 23	Yrs.		12/2/8			Day, Year) Country) Wash., I		
	pur *		Usual Residence of Decedent 10a. State 10b. County	10c Cih	y, Town or Lo	cation					10d. fnside City Limits	
	anyla eho	5									1 Yes 2 No	
	28a-1	Director	Md. Prince (George's L	andove	r Hills			10g. Citizen o	f What Co		
	with with		4001 70th Aven	16			20784			S.A.	21 (t) y :	
	deeth with the Maryland me 23a or 28a-f ehow finant be natilised at	Funeral	11. Marital Status	12. Was Decedent Ever in U.	.S. 13. V	Vas Decedent of Hi		(Specify Yes or N	o- 14. Ra	ace - Amer	ican Indian,	
0	riter of	필	1 ☑ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No	į II	Yes, specify Cuba	in, Mexican, Pu	erto Rican, etc.)	BI	ack, White Δ f		
212-0036	filed within 72 hours after deeth with the Marylan Hygiene. ther then instural; or iteme 23s or 28s-f show ont, the Modical Examiner must be notified at	Ď	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give 12 Year or Dates:	1	☐ Yes 2X No	Specity:		Spec	ify: Ar	frican- merican	
<u>۾</u>	72 hc	Completed	15. Decedent's t		16a. Deced	lent's Usual Occupa	ation	vorkina	16b. Kind of	Business/l	ndustry	
N	thin a	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired)	· • · · · · · · · · · · · · · · · · · ·				
N	be filed withing Hygiene. Id other then event, the M	Š	11th		La	ndscaper				lscapi	ing	
Maryland		Be	17. Father's Name (First, Middle, Las					lame (First, Middl				
<u>\alpha</u>		ဥ	Duane C. Mar					erly J. I				
<u>a</u>	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship			g Address (Street a						
	other tr		Duane C. Marsha		4001	70th Ave	.,Lando	over Hill	S.Md. 20c. Location			
saltimore,	Pages nent of h nnt: if ite ury or of		N☐ Burial 2 ☐ Cremation 3	Removal from State	emetery, cren	natory or other plac	1		200. Location	1 · Oity of 1	own, State	
	rtmer rtent		4 Donation 5 Other (Spec	ALL ALL AND ADDRESS OF THE ABOVE THE		Mem. Park		6/06	Landover		20785	
g n	permit. Pages Depertment of I Importent: if its any injury or of once.		21. Signature of Funeral Service Lice	0 -		Name and Address	ington	& Sons C	o.,Inc.			
			23a. Part 1. Enter the disease, or co	mplications that caused the death	h Do not ente	4925 Burr	oughs A	ve.N.E.	,Washin	gton,	D.C.20019	
			shock, or heart failure. List onl Immediate Cause (Final	y one cause on each line.				1.04	a		Interval Between Onset and Death	
	Pnysician /Medical		disease or condition resulting in death)	a. Intraora		ishet d	WOUS	0				
	Examiner			Due to (or as a consequ	uence or):							
		ĕ	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	uence of):							
	d ansit	듵	cause. Enter Underlying Cause (Disease or injury that initiated events									
<u>,</u>	exec an an	Examin	resulting in death) Last	Due to (or as a consequence	uence of):							
6876U,	te be ysicie	Cal		d								
ğ	es that the death certificate be executed gned by the attending physicien and be detached for use as the buriat-transit	Medical	IF FEMALE:								12 22	
\smile	ith ca tendi		23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy				Date of defi	very Day Year	
. E	e death the atter	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of di 9 ☐ Unknown	eath 5	Other (specify)			,	HOHEI	Day Toal	
J.	law requires that the as been signed by th 2 should be detache	Physician	Part II. Other significant conditions	contributing to death but not rec	ulting in the u	adachilas causa sur	on in Part I	23e Did	tohacco use co	entribute to	the cause of death?	
Š,	signe d be o	ğ	Part II. Other signment conditions	contributing to death but not res	aiting in the u	ideniying cause givi	on at raiti.		Yes 2 No		obably 4 DUnknown	
Ö	w requir been si should	Completed						-				
ě	The law sete has t page 2 s	ig E							s an 24b opsy formed?	prior to d e th?	topsy findings available completion of cause of	
or Vital Records,	en: The tificete hi tor, page								2 No		2□ No	
=======================================	6.0	Be	25. Was case referred to medical examiner?	Hospital:		Oth	ec.	Death Check only	- 100		00000	
ō	Phys rthis rat dii	<u>۲</u>	tX Yes 2 No 27. Manner of Death	1 □ Inpatient 2 □	ER/Outpatien	1 3 DON	4 🗀 Nursini	9 Home 5 ☐ Res	how injury occ		cify) scene	
o	ding h. Afte fune	ē	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigate	28a. Date of Injury (Month, Day Year)	Injury	Worl	k? Yes 2 2 No	Gad it	of cho	f 50	1£	
Division	or Attending siter death. Director: After in by the fune	fica	3 Suicide 6 ☐ Could not	be 28e. Place of Injury - At ho	ome, farm, str			28f. Location	(Street and Nur	nber or Ru	ral Route Number,	
É	effer Direct	Certification;	4 Homicide determine	building, etc. (Specify	At ho	me			Kewcol	Rol 1	valderf. MD	
	Hospital 24 hours Funerel letely filled			Physicien: To the best of my kno	wledge, deati	occurred at the tin		ace, and due to th	e cause(s) and r	manner as		
	To the Hospital or within 24 hours efter To the Funeral Discompletely filled in	Medical	(Check only 2 Medical Expone)	eminer: On the basis of examina and manner stated.	ition and/or in	vestigation, in my o	pinion, death or	courred at the time	e, date and place	e, and due	to the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	10		29c. Licens	e number		29d. Date sign	ned (Monti	n, Day, Year)	
			Cahil	Cos H		COME			Februar	ry 23,	2006	
	1		30. Name and address of person wh	o completed cause of death (Item	n 23a) (Type,		Ct	D=1+-!	- 7 7	01.004		
	- 1		LABILICES	14 / /		III Penn	street,	Baltimore,	maryland	Z1ZC1		
		ate	31. Date filed (Month, Day, Year)	37 Registrar's Signa	ature .	all's						
B	Regist		MAR 0 2 20	106 Down A	14							
DH	MH 17 Rev 1/2	2001										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene 1 1 5

			1 - For State Registrar	State of IV	C	ertificate of		nemai ny	Reg. No.	10	RIMON
	Dhysisi	- -	1. Decedent's Name (First, Middle, Las	st)				2. Date of De Month	aath Day	Year	3. Time of Death
1	Physici /Medio		King Solomon M	ırray, Jr	J			Februa	ary 24,2	2006	2:50 P. M
1	Examir	er	4a. Facility Name (If not institution, give				r Location of Death		4c. Count		
		\$2-E	Southern Maryla			Clint					eorge's
惠	Funeral Director		3/9-36-00/1		ge (In yrs. last birthda 3 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Date 9/7/4)	ay, Year)		place (State or Foreigr ntry) hD.C
	land w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits
	Mary Inch	ţō	Md. P	.G.	Clinto	n					1XYes 2 No
	h the	lrec	10e. Street and Number		0111100	10f. Zip Code			10g. Citizen of	What Cou	ntry?
	th wit	a	7404 Pembroke I	Orive		20	735		U.S.	Α.	
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "naturel", or items 23s or 28s-f show or other traumatic event, the Medical Exertinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Yes 20 If Yes, Give Year or Dates:	?	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 → No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	o- 14. Ra Bla Specii	ck, White fy: Af:	can Indian, etc. rican- erican
5-0	72 hc	etec	15. Decedent's Ed (Specify only highest gra		(Gi	cedent's Usual Occup	during most of work	kina	16b. Kind of E		
12	12 should be filed within 7 h and Mental Hygiene. 7 le marked other than " traumatic event, tre Med	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	. DO NOT use retired	d)	9			
2	iled v tygie ther t		17. Father's Name (First, Middle, Last)	2 yrs.	In	spector	18. Mother's Nam	o /Eirst Middle			artment
Maryland	d be f ental h ed ol	Be c	King S. Murray							me)	
7	should nd Me mark mati	T _o	19a. Informant's Name/Relationship		19b. Ma	iling Address (Street		ce Thoma		State Zi	o Code)
<u>®</u>	nd 2 suith ar with ar 27 is		Brenda A. Murray			04 Pembrok					
ē,	f Health tem 27 other tr		20a. Method of Disposition		20b. Place of Dis	position (Name of rematory or other place	1	Date	20c. Location		
E O	Pages nent of I int: if it		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 5 □ O			y Mem. Par	1	16	Landove	r Mo	3
Baltimore,	permit. Page Department o Importent: ff eny injury or once.		21. Signature of Funeral Service Licer	W. CA	ats	22. Name and Addre	ss of Facility ington & roughs Av	Sons Co	Tnc		
1			23a. Part1. Enter the disease, or com	plications that cause	d the death. Do not e	enter the mode of dyin	ng, such as cardiac	or respiratory a	rrest,	D.C.	20019 Approximate
4	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. <u> </u>	TROK	E					Interval Between Onset and Death
	Examiner			Due to (or a	s a consequence of):	-176100	. (
	***	Ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):	10124J	7				
	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,							
Ć	icate be executed physician and s the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as	a consequence of):						
68760,	te be ysicia	edical	(d							
	rtificate ng physi as the		IF FEMALE								
P.O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death	B Ectopic pregnancy Double (specify)	/			ate of deliv onth	ery Day Year
	that		Part II. Other significant conditions of	ontributing to death	but not resulting in the	underlying cause giv	en in Part I.	23e. Did 1	tobacco use con	tribute to t	he cause of death?
rds	quires n sign	d by		DIAB	RTES	MELLIT	25	1 🗆	Yes 2□No	3 Pro	bably 4 ∐Unknown
Records,	s been s should	lete						24a. Was	an 24b.	Were auto	opsy findings available
Re	The lay	Completed						auto	psy ormed?	death?	opsy findings available impletion of cause of
Vital	ician: Th certificate ector, pag	Be C	25. Was case referred to medical				26. Place of Dea	1 Yes		1 🗌 Yes	2∐ No
<u> </u>	ysician: is certific director,	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 Inpat	ient 2 ☐ ER/Outpat	ient 3 DOA Oth	ar		dence 6 Oti	her (Speci	fv)
ion of	ding I. After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, D	ury 28b. Time	of 28c. Injur Wor			how injury occur		97
Division	in Diffic	Certification:	3 Suicide 6 Could not be determined	289. Place of it	ijury - At home, farm, tc. (Specify)	street, factory, office		28f. Location (City or To	Street and Num wn, State)	ber or Run	al Route Number,
	To the Hospital or Attentwithin 24 hours efter death To the Funeral Director: completely filled in by the	Medical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the bes niner: On the basis and manner s	t of my knowledge, de of examination and/or tated.	ath occurred at the tin investigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and m date and place,	nanner as s , and due t	stated. o the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signe	ed (Month,	Day, Year)
)			machine	Cunc		De	+8158		FEB 2	6, 7	2006
0	(5)		30. Name and address of person who								
			Sisom OSIA, 619	1 2	IL RD#!	0X0 0X0	N HILL	MO	2074	5	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 2 2006	32. Regist	rar's Signature	AL.					

			1 - For State Registrar	State of M	Maryland / Dep	artment o <i>rtificate d</i>		ind Mei		ene	6 (184	20
ı	Physici		Decedent's Name (First, Middle, La JOHN	*	MARTIN				Date of Death Month BRUARY	Day	Yeer 2006	3. Time of 1:45	
	/Medic Examin		4a. Facility Name (If not institution, give		r)		m, or Location of	f Death		4c. County	of Death		•
			2701 Pinecreel 5. Social Security Number 6.5		ge (In yrs. last birthday)		strict ear If Under 2		S Date of Birth	Pri		George	
	Funeral Director			M 2□F	55 Yrs.	Months Da		Min. A	(Month, Dev.	°1′950	Was	lace (State	or Horeign C
			Usual Residence of Decedent										
	anylar	ř	10a. State 10b. County	a	10c. City, Town or Li			1			1	0d. Inside C	City Limits s 2 □ No
	tha M	Director	Maryland Prince 10e. Street and Number	George's		10f. Zip Coo	rict He	ignts	10	- Citi	4/h - 1 O		
	eth with the Marylan 23e or 28e-f show wat be notified at					Tor. Zip Coc			10	g. Citizen of \			
	deeth me 23	Funerai	2701 Pinecro	12. Was Deceder	t Ever in U.S. 13.	Was Decedent	2074 of Hispanic Orig Cuban, Mexican		Yes or No-	14. Rac		an Indian,	
9	after dee or iteme	Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces 11/2 Yes 2 [] No	1 Yes 2		, Puerto Ric	an, etc.)		k, White,		
21215-0036	d within 72 hours after deeth with tha Maryland jene. Ir than "natural", or iteme 23a or 28a-f ehow tre Medical Extropress rout be inclined an	d by	3 Widowed 4 Divorced	Year or Dates	VIETNAM					Specify	נת	Lack	
15	n 72 h	Completed	15. Decedent's E (Specify only highest gr		16a. Dece (Give	dent's Usual Od kind of work do DO NOT use re	ccupation one during most stired)	of working	1	6b. Kind of B	usiness/Ind	dustry	
212		omp	Elementary/Secondary (0-12)	College (1-4o	r 5+)		hef				Priva	ıte	
פ	Hy Hy ent,	BeC	17. Father's Name (First, Middle, Last)			18. Mothe	r's Name <i>(F</i>	irst, Middle, M	aiden Suman	ne)		
ylaı	2 should be and Mental is marked campatic every	To	Joseph D. M.	artin					Sar	ah Whi	te		
Baltimore, Maryland	and and		19a. Informant's Name/Relationship	• • • • • • • • • • • • • • • • • • • •			reet and Numbe						
e,	of Health of Health litem 27 i		Dana Saddler/1 20a. Method of Disposition	Daughter	2 / 0 20b. Place of Dispe		reek Pla	ace, I		t Heig Oc. Location -			1/4/
no.			1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		e cemetery, cre	matory or other	place)						
Ħ			21. Signature of Føheral Service Lice		Maryland	Vetera: 2. Name and Ad	ns Cem. ddress of Facility		vart Fu	Chelt		n, MD	
ä	permit. Departr Imports any Inle		b lolin T.	Lewort	III	4001	Bennin					20019	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caus	ed the death. Do not en line.							Approxima Interval Be	etween
	Physician		Immediate Cable (Final disease or condition	a. PANCR	EATIC CANCE	R						Onset and	Death
	/Medical Examiner		resulting in death)	Due to (or a	is a consequence of):								
Н		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or a	is a consequence of):								
	d d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	C									
o,	e axec ien an ırial-tı	Exe	resulting in death) Last	Due to (or a	is a consequence of):								
8760,	death certificate be axecuted e attending physicien and id for use as the burial-transit	dicai	•	d									
9 X	eath certific attending p I for use as t	l w	IF FEMALE:	23c. If yes, outcom	ne of pregnancy					224 02	te of delive	251	
Вох	death a atter d for u	Physician/M	23b. Was decedent pregnant in the past 12 months?			☐Ectopic pregnation of the country					nth	,	Year
0.	the y th	hys	9 Unknown	9□ Unknown									
	es the	by	Part II. Other significant conditions	contributing to death	but not resulting in the u	inderlying cause	e given in Part I.		23e. Did toba				
Records,	w requir been si should	Completed							1 ∐ Yes	2 □ No	3 Prob	abiy 4X]Unknown
3ec	B 8 0	mpie							24a. Was an autopsy		Were auto prior to cor death?	psy findings mpletion of	available cause of
	an: The l tificate ha tor, page	e Co	25. Was case referred to medical						perform 1 Yes 2		1 🗆 Yes	2 X No	
Vital	Physiclan: this certific al director,	o B	examiner? 1 Yes 2X No	Hospital: 1 Inpa	tient 2 ER/Outpatie	nt 3 DOA	Other		heck only one 5 X Resider		er (Snecif	v)	
J O		n: T	27. Manner of Death	28a. Date of In (Month, L			Injury at Work?		l. Describe hov			77	
Sior	Attending r death. ector: After by the funer	satio	2 Accident investigation	n	,,,,,,		1 Yes 2 1	No					
Division		Certification:	3 Suicide 6 Could not 1 4 Homicide determined	28e. Place of I	njury - At home, farm, st etc. <i>(Specify)</i>	reet, factory, off	fice	28f.	Location (Stre City or Town,		er or Aura	Il Route Nur	nber,
נו	To the Hospital or within 24 hours after To the Funeral Dir completely filled in		29a. Certifier 1 Certifying P	nysician: To the her	st of my knowledge, dea	th occurred at the	ne time, date and	d place and	due to the co-	sels) and m	inner as a	tated	
	e Hospital	Medical	(Check only 2 Medical Exa	miner: On the basis and manner	of examination and/or in	vestigation, in r	my opinion, deat	th occurred	at the time, da	e and place,	and due to	the cause	(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier	4.4	٨	29c. Lic	cense number		29	d. Date signe	d (Month,	Day, Year)	
	0		Robert In	lod lais	th, 19.0.	#	D31411		FI	EBRUAR	23,	2006	
2	(3)		30. Name and address of person who ROBERT G. WADLET				трргт м	LJ LJA	SHINCTO	א הכים	0/22	/689	
	Sta	ato	31. Date filed (Month, Day, Year)		strar's Signature	DILLIA.	TUBEL N	77 7 W.C.L.	CHINGIO	11,00 2	U444	, 000	
	Sta Regist		MAR 0 1 200		. K Ano	de							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Trems 23a, pt. 11 per doc 8353 3-29-06 vt.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 2006 Bernice Chollie Bell Moody February 20 5:00 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3846 - 28th Avenue Temple Hills Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 1 ☐ M 2 🛣 F Months Yrs 579-42-5564 21. 1928 North Carolina Usual Residence of Decedent 10a State 10b Count 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Maryland Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3846 - 28th Avenue 20748 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: **Black** 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Health Care-Dietician Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Washington Garris Eular Brown 19a. Informant's Nama/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earnestine Hill/Daughter 11500 Trillum St., Mitchellville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Harmony Memorial Park 2/25/2006 4 Donation 5 Other (Specify) Landover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 8 1 Revous 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dyog, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. **end stage renal disease** Pproventh. Immediate Cal se (Final disease or condition Onset and Death corona articu ear resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? anorexia 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Tes 2 📆 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA \$**₹**№ 1 Tes 28a. Date of Injury (Month, Day Year) Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed es the burial-transit and Division of Vital Records, P.O. Box 68760, ettending physicien ō detached the ģ been signed should be page 2 certificate After this funeral within 24 hours efter death To the Funerel Director: filled in by

Physician

/Medical

Examiner

Directo

Funeral

þ

Completed

Be

ဥ

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

Medical

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene.
Importent: If item 27 is marked other then *naturel', or iteme 23e or 28e-1 show eny injury or other treumatic event, the Medical Executar must be notified at once.

Physician

/Medical

Baltimore, Maryland 21215-0036

State Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



29c. License number

D38158

Lisa A. DiMarzio,

29d. Date signed (Month, Dey, Year)

			For State Registrar	State of Ma	ıryland		rtment of He		d Mental Hy	giene Reg. No.	08422
	Physici		1. Decedent's Name (First, Middle, Last)	beth McDo	nald				2. Date of Dea Month March	3, 2006	ar 8:13 A M
	/Medic Examin		4a. Facility Name (If not institution, give s Southern Maryland				4b. City, Town, or Clin		eath	Prince	Geroge's
-	Funeral Director		234-24-7225	7. Age	(In yrs. la:	st birthday) Yrs.	If Under 1 Year Months Days	Hours N	Hrs. 8. Date of Bird Month, Da Jan. 27	y, Year) , 1918 We	Birthplace (State or Foreign Country) st Virginia
	se Maryland Ba-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Charles		10c. City,	Town or Lo	orf				10d. Inside City Limits 1 ☐ Yes X☐ No
	s 23e or 2	Funeral Director	70 Village Street,	Apt. 407		13.1	10f. Zip Code 206		2 (Specify Ves or No	10g. Citizen of Wha	•
036	urs after de el', or Item Exeminer	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	lo			Specify:	? (Specify Yes or No uerto Rican, etc.)	Black, V	White etc.
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Importent: If item 27 is marked other than "neturel", or items 23e or 28e-f ehow any injury or other traumatic event, I'm Medical Examinar matal ke mullied at anone.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		+)	(Give life. L	lent's Usual Occupa kind of work done do OO NOT use retired) CE Repres	uring most of		16b. Kind of Busin	ess/industry unications
land 2	uld be filed v dental Hygie rked other t tic event, th	To Be Co	17. Father's Name (First, Middle, Last) Angelo Gialdella			,		18. Mother's	Name (First, Middle, Pah Edna D	Maiden Sumame)	411104010110
Mary	nd 2 shoulth and h		19a. Informant's Name/Relationship (Ty) Rita Wood - Niece	pe, Print)					Rural Route Number, Carson		
more,	Pages 1 ar		20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State	cer	ce of Dispo	sition (Name of natory or other place) Cemetery)	Date -7-06	20c. Location - City Baltimor	or Town, State
Balti	permit. Departm Importe eny inju		21. Signature of Funeral Service License VacA-Lule	ا	M0124		Name and Address			d Washing , Waldorf	ton Rd. , MD 20604
8760,	Physician publical Examiner the pniral-Itansit	ıl Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a conseque	KE ence of):	er the mode of dying	, such as car	diac or respiratory a	rest,	Approximate Interval Between Onset and Death
P.O. Box 687	death certif re attending ad for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)	-		23d. Date of Month	delivery Day Year
	law requires that the de es been signed by the a r 2 should be detached f	þ	Part If. Other significant conditions con	-			ALLA				te to the cause of death? Probably 4 \(\subseteq Unknown
Division of Vital Records,	The ete h page	Completed		OST			212		24a. Was autor perfo 1 Yes	rmed? prior	e autopsy findings available to completion of cause of h? Yes 2 □ No
f Vita	Physiclan: The this certificete ral director, pag	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 No	lospital:	nt 2 🗆 E	:P/Outpatier	it_3□ DOA Othe	art .	Death (Check only only only only only only only only	*	Specify)
sion of	ding After fune	Certification: 7	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	M 1 □ Y	at ? ∕es 2 □ No		now injury occurred	
DİXİ	itel or Attenders after death rel Director: led in by the		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et			eet, factory, office		28f. Location (: City or Toi		or Rural Route Number,
	To the Hospitel or At within 24 hours after of To the Funsrel Dirsci completely filled in by	edical	29a. Certiflier 1 1 Certifying Physics (Check only one) 2 Medical Examination		examination				lace, and due to the occurred at the time,		
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	- Lus	-		29c. License		>	29d. Date signed (M	0
1	YD 17		30. Name and address of person who co	empleted cause of d			Print)	8158		MARCH 4	, 2006
	DD D	ate	Sison Osia, MD, 6:	32. Registr	ar's Signati	nte ear	_	, Oxon	Hill, MD	20745	
3	Regist		MAR 0 6	2006	us .	K. B	back				

State of Maryland / Department of Health and Mental Hygiene For State Registre Certificate of Death Reg. No. 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Natthews **Physician** 1510M Óψ /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner omeco a Year If Under 4 Hrs. 6. Sex If Under 1 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 ☑ F Months Min 87 220-34-9779 5/21/1918 DE Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Iteme 23a or 28a-f show any injury or other traumatic event, Ite Medical Examinar must be notified at once. 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits 1 ☐ Yes 2 X No Director Wicomico Eden 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29128 Tanager Way 21822 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 220No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√XNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herman E. Davis Bessie Cropper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Neiswinter 29128 Tanger Way, Eden, MD 21822 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Trinity Garden of Mem. 3/7/2006 Newark, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licenses 108 William St., Berlin, MD 21811 234. Part 1. Enter the disease, or complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval 8etween Onset and Death Immediate Cause (Final **Physician** LNTESTINAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Physician/Medical Examiner for use as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed XPRRTRNS10 resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, ABDOWINAL IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 | Fetal death in the past 12 fronths? Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: HOSPICE Certification: To 1 Tes 2 000 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide cal 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) ţ 29b. Signature and title of certifier 29c. License number DO058410 Zn 2 224 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALISBURY WARIS 262 66 - HULAM 31. Date filed (Month Day strar's Signature State Registrar

Physician

/Medical

Examiner

Funeral

Director

land		10a. State	10b. County		10c. City,	Town	or Location					10d. Inside City Limits
Mary Fish	ţō	Md.	Washi	ngton			Smiths	burg				1 XYes 2 □ No
r 288	Director	10e. Street and Nur	nber				10f. Zi	o Code		10g.	Citizen of What C	ountry?
1215-0036 within 72 hours after death with the Maryland ene. than "natural", or Iteme 23s or 28s-1 show than "matural" at Item or 18s-1 show	ai D	C-1 Was	hington (Court				2178	83		U.S	. A
dea	Funerai	11. Marital Status		12. Was Decedent E Armed Forces?	ver in U.S.		13. Was Dece	dent of Hispanic orly Cuban, Mexic	Origin? (Specify	Yes or No-	14. Race - Ame Black, Whi	
36 after	J.		ed 2 Marned	1 XYes 2 N If Yes, Give	73-7	8	1 Yes	****		, 5.5.,	Concibe	
21215-003 d within 72 hours a giene. or than "natural", or than Madical Exer	d by	3 Widowed		Year or Dates:			S					White
15- n 72 n	lete		15. Decedent's Ed	de completed)		(Decedent's Usu Give kind of wo life. DQ NQT u	ork done during m	ost of working	166	o. Kind of Business	/Industry
within then	Completed	Elementary/Seco	ndary (0-12)	College (1-4or 5	+)			Driver			Bus Lin	.e
ent,	BeC	17. Father's Name	(First, Middle, Last)					18. Mo	ther's Name (Fir	st, Middle, Mai	den Sumame)	
Maryland d 2 should be file th and Mental Hy it7 Is marked oth traumatic event.	To B	Thomas	Robert 1	Neat Sr.					Anna	Mae Kir	ng	
and N		19a. Informant's Na				19b. I	Mailing Address	s (Street and Nun	nber or Rural Ro	ute Number, Ci	ity or Town, State,	Zip Code)
C = 44 F		Paulette	M. Neat	(Wife)					ırt Smit	hsburg,	Md. 2178	3
of He		20a. Method of Disp		Removal from State	20b. Pla	ce of I	Disposition (Na. crematory or c	me of other place)	Date		c. Location - City or	Town, State
Pag Pag ment ant: I			5 Other (Specif)		Smi	ths	burg Cr	ematory	March 2006	10,	Smithsbur	g,Md.
Aaltimore, permit. Pages 1 a Depertment of Hee Important: If Item any Injury or othe one.		21. Signature of Fu	neral Service Licen	S00				nd Address of Fa	,	1252	25 Bradbu	ry Ave.
T 405 # 9		CHE	Loc.	1)avis	M014	114					hsburg,M	
		23a. Part1. Enter the shock, or hea	ne disease, or come rt failure. List only	plications that caused one cause on each lin	the death. e.	Do no	ot enter the mod	de of dying, such	as cardiac or res	spiratory arrest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (a Anoxic			i nos	ning				Onset and Death
/Medical Examiner		resulting in death)	(Due to (or as a			•	5				
* · · · · · · · · · · · · · · · · · · ·	<u>.</u>	Sequentially list con	nditions,	b. Due d (or as a	the							
Asi te	nine	if any, leading to im cause. Enter Unde Cause (Disease or	injury	PSOUDO	M 21	1100) Q.	Sach	1000	00	2/0./-	
y execu and al-tra	Examiner	that initiated events resulting in death) l	ast	C. Due to (or as a	conseque	nce of):	3 (1) 2117	7000		To frie	
Box 68760, Cdeath certificate be executed elettending physicien and dor use as the burial-transit	Sail		l	d	a	to	M 1	nfect	cen			
68 ifficati g phy as th	edi			0.								
Box eath cert ettending for use a	N/S	IF FEMALE: 23b. Was decedent		23c. If yes, outcome of			3 ☐ Ectopic p				23d. Date of de	ivery
the deat by the ett	sicie	in the past 12	□No	4☐Pregnant at			5 Other (s				Month	Day Year
(al Records, P.O. Box ii: The law requires that the death cert frete has been signed by the ettendin or, page 2 should be detached for use.	by Physician/Medical	9 Unknown										
res th	by	Part II. Other signif	CBES T	ontributing to death bu				0 1				o the cause of death?
Records, he law requires to has been signe age 2 should be co	Completed	2 10 C	0000	7 1 -				40100	Conny	1 U Yes	2 No 3 P	robably 4 donknown
Hasb	npie	DISCOR	z D(a)	8 (5) W	pille	12.	>			24a. Was an autopsy	prior to	utopsy findings available completion of cause of
al Fine The ficete I	S									performed 1 ☐ Yes 2 🖻		2 No
Vital Re slcien: The k certificate ha irector, page 2	Be	25. Was case reference examiner?		Hospital:					ace of Death (Ch			
Phys this ral dir	- T	1 Yes 2 27. Manner of Deat		28a. Date of Injur		R/Outp		DA Curer 4		5 Residence Describe how i	e 6 Other (Spe	ocify)
Division of Vital or Attanding Physicien: after death. Director: After this certifical in by the funeral director, p.	Certification:	1 PNatural	5 Pending investigation	(Month, Day	Year)		ury M	28c. Injury at Work? 1 ☐ Yes 2		Describe now i	njury occurred	
Vite of the control o	fica	2 Accident 3 Suicide	6 Could not be determined		rv - At hom	ne, farn				ocation (Stree	t and Number or R	ural Route Number.
Div alor A after Direct	ert	4 Homicide	dotomined	building, etc	. (Specify)			,, -		City or Town, S	tate)	
Division of Vii To the Hospitel or Attending Physicie within 24 hours after death. To the Funeral Director: After this certi completely filled in by the funeral direct		29a. Certifier	1 Certifying Ph	ysicien: To the best of	of my knowl	ledge,	death occurred	at the time, date	and place, and o	due to the caus	e(s) and manner a:	s stated.
n 24 or Fu	edical	(Check only one)	2 Medical Exen	niner: On the basis of and manner sta	examinatio	on and/	or investigation	n, in my opinion, d	leath occurred at	the time, date	and place, and due	e to the cause(s)
To the I	Σ	29b. Signature and	title of certifier				29	c. License numbe	ər	29d.	Date signed (Mont	th, Day, Year)
1		Ju	um O	· Decese	200)	1	1006	117	MA	RCH 11	2006
17		30. Name and addre	ess of person who	completed cause of de	ath (Item 2	23a) (T		- 0				
7		Francis	W A	Daniel	De De)	251	E. Ant	netam	51-	17 0500	irour MD
Sta Registr	in .	31. Date filed (Mon.	-	2006 32. Hagistra	irs Signatu	*	fresh	,				
DHMH 17 Rev 1/2			MAR 2 0	2000								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** A M 019 3 2006 2:00 March /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (Innot institution, give street and number) Examiner Montgomery 12912 Churchill Ridge Apt I Germantown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 🕱 F El Salvador 1932 73 Yrs. July 1, Director 213-39-6211 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a State 10c. City. Town or Location or 28e-f show Pages 1 and 2 should be filled within 72 hours after death with the Maryla nent of Heath and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28e-1 show arty or other traumatic event. It a Madical Examinatinat be notified at 1 ☐ Yes 2 😾 No MD Germantown Montgomery **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20874 El Salvador 12912 Churchill Ridge Apt I 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married 1\(\text{Yes}\) 2\(\supersize No\) Specify: El Salvadorian Specify: White Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 6 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Emilia Lara Jesus Nolasco ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 19a. Informant's Name/Relationship (Type, Print) Noe Nolasco / Son 2503 Glenallan Avenue Apt 2, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If ite
any injury or ot March 11 2006 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Usulutan, El Salvador Usulutan Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 1 RACUS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) year Physician Kena /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenced) Examiner and I-transit requires that the death certificate be executed Due to (or as a consequence of): the attending physician a ned for use as the burial-Physician/Medical ası IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4⊡Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. ρ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐No 24a Wasan autopsy performed? has 1 Yes 2 No certificete To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director; After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ပ 28d. Describe how injury occurred funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

P.O. Box 68760. Division of Vital Records,

3

State Registrar

Medical

30. Name and address of person who comp

29c. License number

29d. Date signed (Month, Day, Year)

ause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Starting Gate Ut

3,2006

WOODBINE MD 21797

Richard Stefanacci 31. Date filed (Month, Day, MAR 6 0

29a. Certifier

(Check only one)

29b. Signature and title of

3250 Registrar's Signature

and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 2 per dvr 9853 3-20-06 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2006_{Yea} 2 Date of Death Decedent's Name (First, Middle, Last) **Physician** Clayton Oster В. MARCH 9TH. 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND
If Under 1 Year | If Under 24 Hrs. ALLEGANY 8. Date of Birth Month, Day, Year Sep 14, 1920 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min MD" 1 € M 2 □ F 85 Yrs. Director 217-10-1448 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City. Town or Location 10a State 10d, Inside City Limits ir than "natural", or itema 23a or 28a-f show the Madical Examiner must be notified at MD Allegany Cumberland 1 Xes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 12610 Ruppenkamp Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) at Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) laborer Celanese 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be finent of Health and Mental Fant: if item 27 is marked of Lenora Boor Oster Charles Oster ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8914 Winchester Road Front Royal VA 19a. Informant's Name/Relationship (Type, Print) 22630 8914 Winchester Road Robert Oster son item 27 i 20b. Place of Disposition (Name of cometery, crematory or other place)
Sunset Memorial Park Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Himportant: If its any injury or ot once. 1 XBurial 2 Cremation 3 Removal from State 3/11/2006 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, P.A. 21. Signature of Funeral Service Licensee 108 Virginia Avenue; Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a/Part1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician a SEPTIC SHOCK 12 HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner BACTERIAL PERITONITIS 24 HOURS Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit CIRRHOSIS 5 YEARS Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day ٥ Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. I ed by the a 9 Unknown signed l I be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy rmea? 2∭ No 1 ☐ Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Rother (Specify) 1 ☐ Yes 2 ☒ No Certification: To 1X Inpatient 2 EP/Outpatient 3 DOA E S funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending death. 1 Tes 2 No 2 Accident investigation within 24 hours after deat To the Funeral Director: 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) å 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D25406 MARCH 10TH, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM D., M.D., 900 SETON DRIVE, CUMBERLAND, MD 21502 42. Registrar's Signature 31. Date filed MAR 2 0ar 2006 State Registrar

			1 - For State Registrar	State	of Mar	yland /			nt of H te of L			lental l		ene 0	6	08427
	Physicia	an	1. Decedent's Name (First, Middle	e, Last)								2. Date o		Day	Year	3. Time of Death
	/Medic		Marion O									Febru	ıary	22 2	2006	2:28 P M
	Examin	er	4a. Facility Name (If not institution	•		-141		4b. City	, Town, or					4c. County		C
	Funeral		Larkin Chase I 5. Social Security Number	6. Sex		altnca (In yrs. last bi		If Unde	er 1 Year	Bowi If Under		8. Date o	f Birth			George's
	Funeral Director		251-10-6545	1∰M 2□F		88	Yrs.	Months	Days	Hours	Min.	Month Mar.	Dav. Y	^{'ear)} 1917	South	lace (State or Foreign try) Carolina
pu	>		Usual Residence of Decedent 10a, State 10b, County			10- Cit. T.										
lanyla	ods M	ž		ce George		I0c. City, Tov	vn or Loc		Bowie						1	0d. Inside City Limits 1 XYes 2 No
the N	28a-f	Director	10e. Street and Number						ip Code				100	. Citizen of	What Caus	
with	3a or		15005 Hea	ith Conta	n Dr	i.w.o		101.2	p oode	2071	6		100			•
death	ms 2	nera	11. Marital Status	12. Was De	cedent Ev		13. W	/as Dece	edent of Hi			ecify Yes o Rican, etc.	r No-	14. Ra	ce - Americ	
after	or the	by Funeral	1 Never Married 2 Marr	Armed F	Forces? 2 □ No Bive			_		n, Mexican Specify:	i, Puerto	Rican, etc.	.)		ick, White,	
Jours	LEXE.	d by	3 ☐ Widowed 4 ☑ Divorced	Year or	Dates:	200			2[X No					Specif	y: BJ	Lack
n 72 i	nat	Completed	15. Decedent (Specify only highes	's Education it grade completed	1)	16a	(Give k	ind of w	ual Occupa ork done d use retired)	urina mosi	t of work	ing	16	ib. Kind of B	Business/Ind	lustry
withi	than	duic	Elementary/Secondary (0-12) 6th	College	(1-4or 5+)	·	111 G. D	_						т.	Privat	
pelil e	other other	a)	17. Father's Name (First, Middle,	Last)					ress		ır's Name	e (First, Mic	ddie, Ma	iden Sumar		_e
nd be	Aenta rked tic ev	To B	Monroe O	dom								Ethe!	L Gr	aves		
2 sho	and h		19a. Informant's Name/Relations	nip (Type, Print)		191								City or Town		Code)
and	ealth m 27 ner tr		Beverly Y. Pa	ayne/Daug	ghter					r Pla			Ma	r1bor	o, MD	20772
98 1	Department of Health and Mental Hygiene. Important: If item 27s or 28a-f show Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, It is Medical Examiner must be notified at once.		20a. Mathod of Disposition 1 Burjal 2 Cremation	3 Removal from	n State	20b. Place of cemete	of Dispos ary, crem	ition (Na atory or	ime of other place	9)		Date	20	c. Location	- City or To	wn, State
r. Pa	tant:		'4 □Donation 5 □ Other (S)	pecify)		Mary1										am, MD
Dermi Dermi	Depar Impor any ir once.		21. Signature of Furieral Service	Licensee	A	TITT	22.		ind Addres					neral		
			23a. Part1. Fifter the disease, or	complications that	Tout	o death Do	not onto							wash.,	, DC 2	20019 Approximate
	ysician Medical		shock, or heart failure. List Immediate Chrise (Final disease or condition resulting in death)	a	each me.	ac Arr	ythm				our diac (or respirato	y arres			Interval Between Onset and Death
	aminer			Due to	o (or as a o	consequence	of):									
		Jer	Sequentially list conditions, if any, leading to immediate	b. — Due to	o (or as a c	consequence	of):									
cate be executed	physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c												
, e exe	ian ai urial-t		resulting in death) Last	Due to	o (or as a	consequence	of):									
ate b	hysic the b	dical		d												
	ding p	(D)	IF FEMALE:	23c. If yes, o	utcome of	Drogn angu								T		
Physician: The law requires that the death certif	attending I	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2	□ Fetal death ne of death		Ectopic p Other (s	regnancy						ite of deliver onth	ry Day Year
F ed	y the	ysk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unk		ne or dea(ii	30	Other (S	pecily)				_			
that	signed by the a		Part II. Other significant condition	ns contributing to	death but	not resulting	in the und	derlying	cause give	n in Part I.		23e. D	Did tobac	cco use cont	tribute to the	e cause of death?
quire	n sign	ed by	Demen	tia								1	Yes	2 🗆 No	3 🗌 Proba	ably 4 XUnknown
a v	s been si	Completed	Failu	re to thr	cive							24a. V	∵ Vasan	24b.	Were autop	sy findings available
The	ate has	mo		C CO CIII								1 ☐ Ye	utopsy	d?	prior to condeath? 1 Yes	npletion of cause of
ian:	is certificate hadirector, page	Bec	25. Was case relerred to medical examiner?							26. Place	of Death	(Check of		XIVO	10103	20 140
hysic	this ce al dire	To	1 Yes 2 XNo	Hospital: 1	Inpatient	2 ER/0	utpatient	3 🗆 D	OA Othe	r. 4 Nu	rsing Ho	me 5 🗆 F	Residenc	e 6 🗆 Oth	ner (Specify))
	- m	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date (Mo	e of Injury onth, Day Y	/ear) 28b.	Time of Injury		28c. Injury Work	at ?				injury occur		
ttend	tor: /	Certification;	2 Accident investig 3 Suicide ↑ 6 Could n	ot be				М		es 2 l						
or A	after o	ertif	4 Homicide determi	ned 286. Plac buil	ding, etc. (- At home, fa (Specify)	arm, strei	et, facto	ry, office				Town, S		oer or Rural	Route Number,
spital	ours neral filled		29a. Certifier X Certifyin	g Physician: To th	ne hest of r	mv knowleda	e death	OCCUITA	1 at the time	e date and	d place :	and due to	the caus	e(e) and m	20001 20 012	atod
the Hospital or Attending	24 h e Fur letely	edical	(Check only one) Medical I	Examiner: On the	basis of ex	xamination ar	nd/or inve	stigation	n, in my op	inion, deat	th occurr	ed at the ti	me, date	and place.	and due to	the cause(s)
To th	within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune.	Me	29b. Signature and title of certifier					29	c. License	number			29d	. Date signe	d (Month, E	Day, Year)
			1///						D5	7028			1	Februs	arv 27	, 2006
.]ر	2)		30. Name and address of person	who completed cau	use of dea	th (Item 23a)	(Туре, Р	rint)							, ,	, 2000
			Aditya Choj			00 Rid			e., S	te. 2	31,	Annap	0 <u>1</u> is	s, MD	2140	1
	Star Registra		31. Date filed (Month, Day, Year) MAR 0 1 2	nne k	Hegistrar's	s Signatu re	hay	85								

MD Montgomery Olicy. Montgomery Montgom	1 1 AM
Physician Medical Examiner Aa. Facility Name (If not institution, give street and number) Ab. City, Town, or Location of Death Ac. County of Death Montgomer;	
Examiner 4a. Facility Name (If not institution, give street and number) MONTONIA CLUB (If Not institution, give street and number) Montgomer: 5. Social Security Number 230-54-4212 1 M 2 F 74 Vrs. 4b. City, Town, or Location of Death Olney Montgomer: Months Days Hours Min. 4c. County of Death Montgomer: Month, Day, Year) Virginia Virginia	
Funeral Director 5. Social Security Number 230-54-4212 Usual Residence of Decedent 6. Sex 7. Age (In yrs. ast birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dax Year) 9. Birthplace (State Country) Virginia 1 M 2	
Director Usual Residence of Decedent 230-54-4212 1 M 2 R F 74 Yrs. Months Days Hours Min. (Month, Day, Year) 4-14-31 Virginia	or Foreign
Ō	
MD Montgomery Olney. Montgomery Montgom	ity Limits
MD Nontgomery Ulfied The state of the state	2 □ No
Mellenium Rehab. Nursing Home 20832 Montgomery Mellenium Rehab. Nursing Home 20832 Montgomery	
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No Specify Specify Black Specify Black Specify Black Specify	
Amed Forces? 1	
Specify: Specify: Specify: Specify: Specify: Specify: Specify: B_LACK 1	
15. Decedent's Education (Specify only highest grade completed) (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry	
[ife. DO NOT use retired)	
College (1-4015+)	
No Barra Homemaker Housewife	
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)	
Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, Last) Willie Williams, Sr. 18. Mother's Name (First, Middle, Maiden Sumame) Addie Finch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17. Machelia Williams / Daughter 18. Mother's Name (First, Middle, Maiden Sumame) 18. Mother's Name (First, Middle, Maiden Sumame) 18. Mother's Name (First, Middle, Maiden Sumame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19c. Machelia Williams / Daughter 190. Roysbury Court - Palmer Psrk, MD 20785	
The state of the s	
Mashelia Williams / Daughter /908 Roxbury Court - Palmer Psrk, MD 20/85 Mashelia Williams / Daughter /908 Roxbury Court - Palmer Psrk, MD 20/85 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location City or Town, State	
20a. Method of Disposition 1 Burial 2 A Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Riverdale Park Crematory 3/01/06 Riverdale, MD 207 21. Signature of Funeral Service Licensee 220c. Location - City or Town, State Riverdale Park Crematory 3/01/06 Riverdale, MD 207 22. Name and Address of Facility Frazier's Funeral Home, Inc.	0.7
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Riverdale Park Crematory 3/01/06 Riverdale, MD 207 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Frazier's Funeral Home, Inc. 389 Rhode Island Ave., N.W.	
21. Signature of Funeral Service Licensee 22. Name and Address of Facility Frazier's Funeral Home, Inc	
23a Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Approximate the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.	te
Onset and	
Physician disease or condition resulting in death) A pue to (or as a consequence of):	
Examiner Charles and the Charl	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury to will be cause (Disease or injury to will be cause.)	
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Cuse to (or as a consequence of): Due to (or as a consequence of): Cuse to (or as a consequence of):	
Due to (or as a consequence of):	
d is see a s	
See that the second transport of the second transport	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1	Year
O 2 5 9 9 Unknown 9 Unknown	i cai
1 Yes 2 No 9 Unknown 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of 1 Yes 2 No 3 Probably 4 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 Ye	doath?
s s s s s s s s s s s s s s s s s s s	
The Service of the se	
1 Yes 2 No 3 Probably 4 1 Yes 2 No 3 Probably 4 24a. Was an autopsy performed? autopsy performed? 1 Yes 2 No 1 Yes 2	available cause of
Per performed? Per performed Performe	
C 5 5 5 6 TENSIONS 5 Pending (Month, Day Year) Injury Work? Passanger on formis wheel with	1
Thatters 2 M Accident investigation investig	
27. Manner of Death 1	ord Rd.
Amusement Park Bethesda, MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
27. Manner of Death Thatman 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28c. Injury at	s)
28. Place of Injury: At home, farm, street, factory, office Suicide Amusement Park	1000
2 Namani Ndalin D0060089 2/24/06	
	/
30 Name and address of person who completed cause of death (Item 23a) (Type, Print) RENCY DAMAW 1, DR. MONTGOMERY CONNERS (HOSPITAL CHARGE) MICH	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar MAR 0 3 2006	

			1 - For State Registrar	State of Maryl		artment of H			giene Reg. No. 006	08429
			Decedent's Name (First, Middle, La	st)				2. Date of Dea	ath	3. Time of Death
П	Physici		Myrtle E	Peraro				Month	Day Yea 2006	A.d
1	/Medic Examin		4a. Facility Name (If not institution, giv			4b. City, Town, or	Location of [4c. County of D	
	Exami		Frederick Memor:	ial Hospital		Free	lerick		Frede	erick
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Birt		Birthplace (State or Foreign Country)
	Director		212-20-1136	□M 2\\ F 8	1 Yrs.	Months Days	Hours	Min. (Month, Day Nov. 18	, 1924 N	/irginia
	P		Usual Residence of Decedent							
	how	_	10a. State 10b. County	100	. City, Town or Lo	ocation				10d. Inside City Limits
	Ba-f-	55	Maryland Carrol	1 1	Mount Ai	ry				1 😡 Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	23a	E .	309 N. Main Str				1771			States
	ems .	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin n, Mexican, F	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
36	or i	by Fi	1 Never Married 2 Married	1 ☐ Yes 2 ☒ No If Yes, Give		1 ☐ Yes 2 ☒ No	Specify:		Specify:	White
8	72 hours after death with the Maryland Insturel', or items 23s or 28s-f ehow disst Examinar must be notified at		3 ☑ Widowed 4 ☐ Divorced	Year or Dates:	10.5				101 151 15	
7		Completed	15. Decedent's E (Specify only highest gr		(Give	dent's Usual Occupa kind of work done o DO NOT use retired	luring most o	of working	16b. Kind of Busine	ss/Industry
12	within ene. then	E	Elementary/Secondary (0-12)	College (1-4or 5+)		omemaker	/		0wn	U ome
2	be filed within tal Hygiene. Id other then 'event, It a Ma	o C	17. Father's Name (First, Middle, Last)	11	Omemaker	18. Mother's	s Name (First, Middle,		Home
au	A 20 €	an l	Cephas Raines	,				1 Reed	,	
Maryland 21215-0036	s 1 and 2 should be f Health and Mental Item 27 is marked other treumatic ev	ဥ	19a. Informant's Name/Relationship	Type Print)	19h Maili	no Address (Street		or Rural Route Numbe	City or Town State	Zin Code)
Z	d2s than 7 is		Denise Tyeryar		1			Mt. Airy,		
	Health Health tem 27 other tr		20a. Method of Disposition		Ob. Place of Dispo	sition (Name of		Date Date	20c. Location - City	
چ	ages nt of nt of t: if it		1 ☐ Burial 2 ☑ Cremation 3 ☐			matory or other place	Ma Ma	arch, 5		
Baltimore,	it. Partme	1	4 Donation 5 Other (Special 21. Signature of pateral Service Lice	-		Cremator			Frederick,	
Ba	permit. Pages: Department of It importent: if ite eny injury or of once.		1 SUR	A	8	E. Ridgev	rille I		Airy, Mar	mes, P.A. yland 21771
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not en	ter the mode of dying	g, such as ca	rdiac or respiratory ar	rest,	Approximate Interval Between
10	Physician		Immediate Cause (Final disease or condition	Be	SPIRM	Tones	And	255/ /1	AILYNE	Onset and Death
	/Medical		resulting in death)	Due to (or as a cor	nsequence of):			/		
	Examiner		Sequentially list conditions,	b. 18	WSE1	25/5				thans - NA
	D =	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor			_		7 /	
	acute ind trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last		INAM	1/4	27	INFACT	'0N	
8760,	be executed sicien and burial-transit		resulting in death) Last	Due to (or as a cor	rsequence of):					-
876	cate be ex physicien a the burial	dical	•	. #		- 111				1
9	The law requires that the death certificate be executed are been signed by the attending physicien and page 2 should be detached for use as the burial-transit	0	IF FEMALE:							
Вох	eath certific attending p I for use as	Physician/M	23b. Was decedent pregnant in the past 12 menths?	23c. If yes, outcome of pri	Fetal death 3	Ectopic pregnancy			23d. Date of Month	delivery Day Year
_	the a	Sic	1 ☐ Yes 2 € No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	of death 5[Other (specify)				
P.0	that the de led by the a detached t	P.	Part II. Other significant conditions	postributing to death but no	t reculting in the	adorbina acusa au	n in Bart I	23a Did to	phages use contribut	e to the cause of death?
	ires ti signe d be d	Ď	L.	THEIME		15EA	_			Probably 4 Unknown
oro	w requir been si should I	ted	72	11-1-	/	02		_ '''	162 5 140 2	
of Vital Records,	law lasb	Completed						24a. Was autop	osy prior	autopsy findings available to completion of cause of
		S						perfói 1 ☐ Yes	rmed? death 2 No 1 □	n? ∕es 2□ No
ĭ;	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?					f Death (Check only o	ne)	
=	d is	2	1 ☐ Yes 2 No		2 DERVOutpatie	nt 3 DOA Othe	ar: 4 ☐ Nursi	ing Home 5 ☐ Resid	dence 6 Other (S	pecify)
0	fter t	ä	27. Manner of Death 1 □ Matural 5 □ Pending	28a. Date of Injury (Month, Day Yea	28b. Time o	f 28c. Injury Work	at ?	28d. Describe h	now injury occurred.	
9.	endi eath. or: A he fu	catl	2 Accident investigation			M 10	res 2□No	0		
Division	irect irect	Certification:	3 Suicide 6 Could not be determined		At home, farm, st pecify)	reet, factory, office		28f. Location (S City or Tow		Rural Route Number,
Ω	rei D									
	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Exa	nysician: To the best of my miner: On the basis of exam	knowledge, deat mination and/or in	h occurred at the tim vestigation, in my or	e, date and pointion, death	place, and due to the o occurred at the time, o	cause(s) and manner date and place, and	as stated. due to the cause(s)
	the I	Med	one)	and manner stated.		20e Lienner	- aumbar		Data sissed (M	onth Day Voor
	To To	-	29b. Signature and title of certifier	1/1/10	110-	29c. License	226	169	Louisigned (M	onth, Day, Year) A ZULL
,	_		1/60	an c	- 12	100		//	, ,,,,,,,,	7 6
1	h		30. Name and address of person who							
			Ronald E. Mill 31. Date filed (Month, Dey, Year)				lt. Aiı	ry, Marylan	nd 21771	
1	Sta Registr	_	MAR 0 7	2006 32. Segistrar's S	J. S.	partie				

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician JOSEPH** 12:50 A M PHILLIP POPKIN MARCH 2006 1 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SUBURBAN HOSPITAL BETHESDA MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 X M 2 ☐ F 079-28-4725 Yrs. Director 71 NEW YORK JAN. 1935 Usual Residence of Decedent with the Maryland 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits ral', or itams 23a or 28a-f ehow Examiner must be notified at 1 ☐ Yes 2 No MD MONTGOMERY BETHESDA Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6810 GREYSWOOD ROAD 20817 USA death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 X Yes 2 No 1957filed within 72 hours after 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No f Yes, Give Year or Dates: Specify: δ Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 1961 "natural" Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry IBM Elementary/Secondary (0-12) College (1-4or 5+) 12 MARKETING SUPPORT MANAGER TECHNOLOGY INDUSTRY 17. Father's Name (First, Middle, Last) permit. Pages 1 end 2 should be file.
Department of Heelith and Mental Hy
Important: If Item 27 Is marked oth
any Injury or other treumatic eveni 18. Mother's Name (First, Middle, Maiden Sumame) Be **JACK** POPKIN FENSTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HINDA POPKIN - SPOUSE 6810 GREYSWOOD ROAD BETHESDA, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FORT LINCOLN CREMATORY 3-6-2006 BRENTWOOD, MARYLAND 21. Signi 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician INTRACRANIAL HEMORRHAGE 3 DAYS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, teading to immediate cause following Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of). physicien a s the burial-Box 68760 Physician/Medical ettending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐ Pregnant at time of death 5 Other (specify) Ö 9☐ Unknown 00 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ds. þ 1 Yes 2 No 3 Probably 4 Munknown Completed Recor 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page certificate 1 Yes 2 No 1 Yes 2 No Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 5 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 0 1 X Natural 5 Pending death. M 1 ☐ Yes 2 ☐ No investigation Director: 2 Accident Division 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funaral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier. 29c. License number 29d. Date signed (Month, Day, Year) D37891 MARCH 1, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. RAJVANSHI, M.D. 121 CONGRESSIONAL LANE #409 ROCKVILLE, MARYLAND 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 06 2006 Registrar

DHMH 17 Rev 1/2001

工

0

010

0

0

	CE ALEC:	IΑ		alalibla lale - 5	Emoure All	Carias Ar	a l a milata				
06 - 01 RJ	470		Please Type or Print in Black in Amend unpend item#1,23a,27,penME,8854,4/2// State of Maryland / Dep	artment of Hea	alth and Me	ntal Hygie	e Legible.	~ ~ 1 ~ 1			
			1- For State of Maryland / Dep State Registrar Amend#5.Per FH PGC 3-14-06c96	rtificate of De	eath	Reg.	211116	08431			
	Physicia /Medic		Q'Nise Alecia Queen				27, 2006	3. Time of Death 3:24 p. M			
	Examiner		4a. Facility Name (If not institution, give street and number) Prince George's Hospital Center	4b. City, Town, or Loc Cheverly	4b. City, Town, or Location of Death 4c. County of Dealh						
	Funeral Director	Completed by Funeral Director	5. Social Security Number 220-73-6999 6. Sex 1 M 2X F 7. Age (In yrs. last birthday Yrs.		Under 24 Hrs. 8 Hours Min. D	Date of Birth (Month, Day, Ye		thplace (State or Foreign buntry) aryland			
_	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Meniat Hygiene. Important: if Item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Example materinal for pulling at once.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation				10d. Inside City Limits			
			Maryland Prince George's	Capito1	Heights	10g	Citizen of Whal Co	1 A Yes 2 No			
The			1324 Karen Blvd.	207	743	109.	United				
_			11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Marital Status 1 (1) Yes 2 (2) (No	Was Decedent of Hispa If Yes, specify Cuban, M	anic Origin? (Speci Mexican, Puerto Ric	fy Yes or No- can, etc.)	14. Race - Ame Black, Whit				
9036			3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 【XNo S	Specify:		Specify: B	1ack			
15-0			(Specify only highest grade completed) (Giv.	edent's Usual Occupation e kind of work done durin DO NOT use retired)	n ng most of working	16b	. Kind of Business	/Industry			
212	ed with /giene. er ther	Comp	Elementary/Secondary (0-12) College (1-4or 5+) None	None			None				
and	shouid be filk and Mental Hy ie marked oth sumatic event	To Be (17. Father's Name (First, Middle, Last) Brian Taylor	18. Mother's Name (First, Middle,			Maiden Sumame) nia Queen				
ary			19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and	Number or Rural F	Route Number, Ci	ty or Town, State,				
Baltimore, Maryland 21215-0036	1 and Health em 27 other tr			24 Karen B1v osition (Name of omatory or other place)	vd., Capi		. Location - City or	20743			
io E	Pages nent of int: if it			matory or other place) Memorial Pa	ark 3/7/2		Landove				
Balt	permit. Depertr Imports any inje		21. Signature of Funeral Service Licensee	2. Name and Address of	Facility St		neral Ho				
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock in heart failure. List only one cause on each line.				asii., Do	Approximate Interval Between			
	Physician /Medical Examiner	aminer	Immediate Cause (Final disease or condition resulting in death) Sudden infant death syndrome (SIDS)								
			Due to (or as a consequence of):								
			Sequentially list conditions, if any, leading to instrudiate cause. Enter Underlying Cause (Disease or injury								
ć	executed in and ial-transit	Ехап	resulting in death) Last C. Due to (or as a consequence of):								
876(tificate be execu g physicien and as the buriat-trai	by Physician/Medical	d								
9 xo	ital or Attending Physician: The law requires that the death certif its after death. Its after death. Tel Director: After this certificete hes been signed by the ettending led in by the funeral director, page 2 should be detached for use a		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d.		Dale of delivery				
P.O. Box 68760,				□Ectopic pregnancy □ Other (specify)				Month Day Year			
Js, P.			Part II. Other significant conditions contributing to death but not resulting in the	her significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
Division of Vital Records,		Medical Certification; To Be Completed				1 ☐ Yes 24a. Was an	24b. Were au	obably 4 Inknown utopsy findings available			
a Re					***************************************	autopsy performed 1/2 Yes 2	? dealh?	completion of cause of			
Vita			25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatie	0.1	5. Place of Death (6 □Other (Sne	cutu)			
o u			27. Manner of Death 1 X Natural 5 Pending 28a. Dale of Injury (Month, Day Year) 1 Injury	of 28c. Injury al Work? 28d. Describe how injury occurred							
visic			2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No reet, factory, office 28		28f. Location (Street and Number or Rural Route Number,					
Ö											
	he Hospitai in 24 hours a he Funerei pletely filled		29a. Certifier (Cineck only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	To the To the comple		29b. Signature and title of certifier	I	d. Date signed (Month, Day, Year) ebruary 28, 2006						
0.10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn						land 21201			
	Sta	te	31. Date filed (Month, Day, Year) 2. Registrar's Signature.			<u></u> .					
	Registr		MAR 1 4 2006 Blee & Gran	de .							

	1	For State Registrar	State of Ma			tificate of			Reg. No.	106	0843
Physician		. Decedent's Name (First, Middle, Last)	-lada-	Samue1	Ro	thblum		2. Date of Dea Month	Day	Year	3. Time of Dea
/Medical Examiner		a. Facility Name (If not institution, give	street and number)			4b. City, Town,	or Location of Deat			ounty of Dea	. - 10 1
	ı	madonna Herita	3982 N/V	DISUINE C	5	Jar	re Hs v.14			1200. La.	·I
Funeral		Social Security Number 6. Sex	7. Age 7. Age	(In yrs. last bin	thday)_ Yrs.	If Under 1 Year Months Days		(Month Day	y, Year)	9. Bi	thplace (State or Fountry)
Director	-	213-38-3650 15	A	89	TIS.			12/12	2/19	16	New Yor
Mou		0a. State 10b. County		10c. City, Town	n or Loc	ation					10d. Inside City Li
life of series		MD. Montgomery Silver Spri				er Spri	ng 1 □ Yes 2 No				
or 20	1	10e. Street and Number 10f. Zip Code					-	n of What C	•		
s 23c		1619 Oakview		Superio II C	10.14	Yan Danadani at I	20903				tates
If them 27 is marked other than "natural, or items 23s or 28s-1 show or other traumatic event, the Modical Examinat must be notified at or other traumatic event, the Modical Examinat must be notified at or other traumatic event. To Be Completed by Funeral Director		1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 XYes 2 □ N If Yes, Give Year or Dates:	WW II		Yes, specify Cub	Hispanic Origin? (Sean, Mexican, Puerl Specify:	to Rican, etc.)		Black, Whi	encan Indian, te, etc. White
t, the Medical Exart Completed by		15. Decedent's Edu		16a.	Decede	ent's Usual Occu	pation during most of wor	rkina		of Business	
mple Men	-	(Specify only highest grade completed) (Give kind of work done during most of wo life. DO NOT use retired)									
CO	5 -	7. Father's Name (First, Middle, Last)			<u> </u>	Machin:	· · · · · · · · · · · · · · · · · · ·	me (First, Middle,			nment
atic even To Be	í	Isadore		Rothl	זוולה	n	Jean		maideri 3	ŕ	Esberg
T		19a. Informant's Name/Relationship (Ty	pe, Print)					ural Route Number, City or Town, State, Zip Code) 20016			
er tra		Richard S. Roth	nblum/So				b St. N				n. D.C.
r oth	2	0a. Method of Disposition 1 □ Burial 2 M Cremation 3 □ R	amoval from State	20b. Place of cemeter	Disposi y, crema	ition (Name of atory or other pla	ce)	Date		ation - City or	
ury o		'4 □Donation 5 □Other (Specify)	emovar nom state	Carro	11	Crema	tion 3/	9/2006	Ham	stea	d. Md.
Important: if item 27 is any injury or other tra ance.	2	21. Signature of Funeral Service/Lidense	Kurk			Name and Address	ess of Facility	Jarrett Son Fun	svi	lle, Hom	Marylande. P.A.
		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that tall and ne cause on each line	the death. Do r							Approximate Interval Between
ician dical	1	mmediate Cause (Final disease or condition resulting in death)	Cardine	Arri	-	Amia					Onset and Deat
niner			ASCUD	consequence of	of):J						12:00
je je		Sequentially list conditions, lany, leading to immediate sause. Enter Underlying Cause (Disease or injury		Leonsequence o	orj.						7000
Examiner	(nat initiated events	1777								Year's
I Ex	ľ	resulting in death) Last Due to (or as a consequence of):									
the burial-transit			l								
page 2 should be detached for use as II Completed by Physician/Med	1 2	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death		Ectopic pregnanc Other (specify)	у		23	d. Date of de Month	livery Day Year
y Ph	Р	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of			o the cause of death
d by P	2	multiple cons Parkinsons					1 ☐ Yes 2 ☐ N		No 3 Probably 4 Unknown		
2 should pleted	1	anemin	Don	nem Hai				24a. Was a		24b. Were a	utopsy findings avail
omp		arriana hellmein						autop perfor		prior to death? 1 \(\sum \text{Yes}	completion of cause 200 No
ector, pag	2	5. Was case eferred to medical examiner?					26. Place of Dea	ath (Check only or	/		
al dire		1 ☐ Yes 2X No	ospital: 1 🗆 Inpatier				4 Nursing H				ocity) Musishul
funer lon:	2	7. Manner of Death 1. Natural 2. Accident 3. Suicide 6. Could not be	28a. Date of Injun (Month, Day	M 1 Yes 2 No							
completely filled in by the		4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
pletely fill	4	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
W Com		29b. Signature and title of certifier 29c. License number 3129				_	29d. Date signed				
	3	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
			5601 Loch		D/1	od Box	30,47	084 B	net,	md.	21239
State		1. Date filed (Month, Day, Year)	32. P	r's Signature		N.					
Registrar		MAR 2 0 2	006	I St.	14						

			1 - For State Registrar	State of M	Marylar	•	rtment of <i>tificate o</i>				ene	6	0843	33
			1. Decedent's Name (First, Middle, Las	st)					2.	Date of Death Month		Year	3. Time of D)eath
	Physici /Medic			Rob	ert (Clayton	Reed		М	arch	4 20		3:00a	М
F	Examin		4a. Facility Name (If not institution, give	e street and numbe	or)		4b. City, Town	, or Location o	of Death		4c. County of	of Death		
			Sunrise Assisted	Living				ederick				deri	.ck	
	Funeral Director		5. Social Security Number 6. S 497–12–1579	ex 7 1⊠M 2□F	Age (In yrs. 87	last birthday) Yrs.	If Under 1 Yes Months Day		24 Hrs. 8. Min. NO	Date of Birth (Month, Day, V. 28,	Year) 1918	Coul	place (State or I ntry) 1essee	Foreign
	<u>p</u>		Usual Residence of Decedent											
	urylar show	L	10a. State 10b. County		10c. Ci	ity, Town or Lo	cation					1	10d. Inside City	
	8a-1	cto	Maryland Freder	ick	Fre	derick							1 X Yes 2	2 140
	or 2	Director	10e. Street and Number				10f. Zip Code	9		10	g. Citizen of W	hat Cou	ntry?	
	23a	ra	990 Waterford Dri					1701	10.0		United			
96	ges 1 and 2 should be filed within 72 hours after death with the Maryland ti of Health and Mental Hygiene. If them 27 is marked other than "natural", or Items 23a or 28a-f show of item 27 is marked other than "natural", or Items 12a or 28a-f show or other traumatic evant, the Madical Examinar must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Deceder Armed Force 1 ☑ Yes 2 [If Yes, Give Year or Date:	s?] No	1	Vas Decedent o Yes, specify C ☐ Yes 2⊠ N		gin? (Specify n, Puerto Ric	Yes or No- an, etc.)		c, White,		
Maryland 21215-0036	hou	ed	15. Decedent's Ed		· WWII		ent's Usual Occ	cunation		1	6b. Kind of Bus		hite	
<u> </u>	in 72	Completed	(Specify only highest gra	de completed)		(Give	kind of work do	ne during most	t of working	ļ '	OD. KING OF DUS	MIGSSAIII	dustry	
7	with the	E O	Elementary/Secondary (0-12)	College (1-4c	ir 5+)		Driver				Dai	rv		
g	Hygie other	0	17. Father's Name (First, Middle, Last)	1			DIAVOI	18. Mothe	er's Name (F	irst, Middle, M	laiden Sumame			
a	ld be lenta kad ic ev	To B	Martin Luther Ree	d				Edna	Sawye	rs				
a Z	should be and Mental I smarked o		19a. Informant's Name/Relationship (19b. Mailin	g Address (Stre				City or Town, S	State, Zij	Code)	
Σ	alth a 27 is		Kenneth W. Davis/S	Son-in-la	W	500 Pa	tton C	ircle U	Jnit K	Freder	ick MD	217	03	
ē,	of He Item		20a. Method of Disposition			Place of Dispos	sition (Name of atory or other p	place)	Date	2	0c. Location - 0	City or To	own, State	
Ĕ	Page nent con int: If		1 🔽 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		te		Cemet	1	3/8/20	06 B1	centwoo	d. M	arvland	ł
altimore,	permit. Pages 1 and 2 Depertment of Health a Important: If Item 27 is any injury or other tra		21. Signature of Funeral Service Licen	1509 1 1	4	22	Name and Ade	dress of Facility	v					
<u>m</u>	89 = 9		Sociel O	upr		16	auffer 21 Opos	sumtown	l Home 1 Pike	, Frede	erick M	D 21	702	
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caus one cause on each	ed the dea line.	th. Do not ente	er the mode of o	tying, such as	cardiac or re	spiratory arre	st,		Approximate Interval Between	een
7	Physician		Immediate Cause (Final disease or condition	· Melo	,	,	ancer		,				Onset and De	11
ĺ	/Medical		resulting in death)	Due to (or a			977		-41/				1 12.01.	- 6-
П	Examiner		Sequentially list conditions	b										
	ם פ	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a consec	quanca ol).								
	ecute and -trans	Examiner	that initiated events resulting in death) Last	C.										
8760,	The law requires that the death certificate be executed ite has been signed by the attending physician and bage 2 should be detached for use as the buriat-transit	E		Due to (or a	as a consec	quence or):								
87	physi the l	dical		d									140	
×	eath certific attending p for use as	/Me	IF FEMALE:	23c. If yes, outcon	ne of prean	ancv					20 d D-11-			
Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1□Live birth	2 Feta	aldeath 3□	Ectopic pregnal Other (specify)				23d. Date Mon		ery Day Ye	ar
o.	that the de led by the a detached t	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		30411	Other (specify)							
σ.	res that igned by be deta	y P	Part II. Other significant conditions of	ontributing to death	but not res	sulting in the ur	derlying cause	given in Part I.		23e. Did toba	acco use contri	bute to t	he cause of dea	ath?
<u>8</u>	n sign	d by	Parkingen's	NIJEG	12					1 ☐ Yes	2 No	3 🗌 Prot	oably 4 Un	iknown
õ	w requires been single should be	jete	Galledonel							24a. Was an	24b. W	/ere auto	ppsy findings av	vailable
æ	The lav te hes age 2	Completed	0 173 74770							autopsy	ed? de	eath?		use of
ā	en: tifice for, p	a	25. Was case referred to medical					26. Place	of Death (C	1 ☐ Yes 2		res	2□ No	
<u> </u>	ysicii s cer direct	ToB	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpa	itient 2]ER/Outpatien	3□ DOA	24			rce 6 □Othe	r (Speci	(v)	
<u></u>	g Ph er thi		27. Manner of Death	28a. Date of Ir		28b. Time of Injury	28c. In				v injury occurre		,,	
<u>ö</u>	ath. rr; Afr	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	ו	Jay / Gar/	inquity		Yes 2 1	No					
Division of Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director; After this certificate he completely filled in by the funeral director, page	Certification;	3 Suicide 6 Could not be 4 Homicide determined	e 28e. Place of building,	Injury - At h etc. (Speci	nome, farm, stre	et, factory, offic	ж	28f.	Location (Stre City or Town,	eet and Numbe State)	r or Rura	al Route Numbe	ar,
٥	oltal c urs al ral D lled ir			-										
	Hosp 24 hor Fund Tely fi	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exan	ysician: To the be niner: On the basis and manner	of examina	owledge, death ation and/or inv	occurred at the estigation, in m	time, date and y opinion, deat	d place, and th occurred a	due to the car at the time, da	use(s) and mar te and place, a	iner as s nd due t	tated. o the cause(s)	
	o the	Mec	29b. Signature and title of certifier	and mainler	Stated.		29c. Lice	ense number		29	d. Date signed	(Month.	Day, Year)	
	⊢s⊢ő		1911.11	11/11	()	170	0	4173	78		RI	1	7.01	
,	Alli		30. Name and address of person who	completed cause of	f death (Ite	m 23a) (Tyne 1	Print)	11] 7	0		1.104	6	2 6	
6	X		Michael W	1 6.11	//.	150	4 On	0.(11	Louis	Pshe	Fre	No -	1 M)
	Sta	te	31. Date filed (Month, Day, Year)		strar's Sign	ature	,	-40 1/2h	1000	· J-CC	114	Y. C.	71	ZOL
€.	Registr	ar	MAR 0 7 2	006	wer .	I do	while						27	700

			1 - For State of Maryland / Dep	artment of Health and Mertificate of Death		giene Reg. No. 106	08434
6	Dhysisi		1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month	ath Day Year	3. Time of Death
	Physicia /Medic		JAMES ELLSWORTH RIDGWAY		Februa	4	2:50 p M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Magnolia Garden Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Lanham If Under 1 Year If Under 24 Hrs.	8. Date of Birtl	Prince Ge	Place (State or Foreign
	Funeral Director		579-10-3422 1\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Months Days Hours Min.	(Month, Day June 1	v. Year) Cou	hington, DC
	p.		Usual Residence of Decedent 10a State 10b County 10c City, Town or L		·		10d. Inside City Limits
	show	7					1 X Yes 2 No
	the M	Funeral Director	Maryland Prince George's Berwyn H	leights 10f. Zip Code	- 1	10g. Citizen of What Cou	intry?
	3a or		5706 Quebec Street	20740		U.S.A.	,
	death	nera		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-		
9	after or Ite	/Fu	1 □ Never Married 2 ② Married 1 ③ Yes 2 □ No 1950 —	1 ☐ Yes 2 No Specify:	r nouri, otory		ite
2-0036	within 72 hours after death with the Maryland ene. than "neturel" or Items 23a or 28a-f show fra Madical Examiner must be millified at	Completed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1962 15. Decedent's Education 16a. Dec	edent's Usual Occupation	-	16b. Kind of Business/Ir	
7	in 72 n "nel	olete	(Specify only highest grade completed) (Giv	e kind of work done during most of work DO NOT use retired)	ing	TOD. TAILS OF DUSTINGSON	laddity
2121	d with giene.	mo	Elementary/Secondary (0-12) College (1-4or 5+) 3 Real	Estate Broker		Own Busines	38
ਰੂ	be filed within 72 hours after death with the Marylan ital Hygliene. Id other than "naturel", or liems 23a or 28a-f show event, it a Madical Examinational banalitied at	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle,	Maiden Sumame)	
<u>ya</u>	2 should be and Mental I s marked o	P _L	William Ridgway	Mary A.			
Maryland	12 sh h and 7 Is m treum		1177	ing Address (Street and Number or Rur			
<u>မ်</u>	1 and Healt em 2		20a Method of Disposition 20b, Place of Disp	B Bodmer Avenue Position (Name of	OOLESV1. Date	Lle Marvlar 20c. Location - City or T	
nor	ages ant of it: If it y or o		1 Burial 2 X Cremation 3 Removal from State	ematory or other place) tan Crematory 2/2.	3/2006	Alexandria	. Virginia
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic as <u>once</u> .		- //	22. Name and Address of Facility Ga.	and the second second		
m	Per Imp		Men L. recludling	4739 Baltimore Ave	nue, Hya	attsville, N	Maryland 2078
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician	f II	Immed/ate Cause (Final disease or condition a. End Sta e Cirrho; result ig in death)	sis - Liver Failur	e		Years
	/Medical Examiner		Due to (or as a consequence of):				
		e r	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate out a first underlying Cause (Disease or injury that initiated events				
o,	exection and and rial-tra	Еха	resulting in death) Last Due to (or as a consequence of):				
8760,	sate be executed physician and the burial-transit	dical	d				
9	death certificate be executed e attending physician and nd for use as the burial-transit	Med	IF FEMALE:				
Вох	eath certific attending pl	Physiclan/Med	in the past 12 months? 4 Pregnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of deliv Month	ery Day Year
Ó	that the de ed by the a detached	ysic	1 U Yes 2 No 9 Unknown				
Δ.	law requires that the as been signed by th 2 should be detache	by Pt	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
rds	w requires been sign should be	ed b	Anemia; Thrombocytopenia		1 🗆 Y	res 2X No 3□Pro	bably 4 Dunknown
of Vital Records,	law requas been 2 should	Completed			24a. Was	osy prior to c	opsy findings available ompletion of cause of
<u> </u>	ysicien: The la is certificate ha director, page 2	Con			1 Tes	rmed? death? 2 No 1 ☐ Yes	2 No
Vita	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Deat Other: 4 Vi Nursing Ho			
of	Physicien: r this certifica ral director, i	. To	1 ☐ Yes 2 ☒ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 2.	SIL 3L DOA 4ANTONISING FIC		dence 6 Other (Spec	ify)
	Attending I r death, ector: After by the funer	tlon	1 XNatural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	of 28c. Injury at Work? M 1 □ Yes 2 □ No			
Division	or Attence after death Director: in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (S City or Tox	Street and Number or Rus	ral Route Number,
Ö	tal or A	Cert	Sunding, etc. (Specify)				
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or				
	thin 2 the I	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month	, Day, Year)
•	F 3 F 8		B. M. Oliver	D01852		February 24	2006
	1 va	+	30. Name and address of person who completed cause of death (Item 23a) (Type	a, Print)		icbidary Z	., 2000
	2/	7		Road, Hyattsville	, Maryla	and 20781	
	Sta		31. Date filed (Month, Day, Year) 32. Degistrar's Signature				
	Regist	rar	MAT. C 3 2006 Brown &	arile	<u></u>		

DHMH 17 Rev 1/2001

Registrar

ROBINSON

LEO

RUSSELL

		1	For State Registrar	State of M	laryland		artment tificate			and Mental Hy	giene Reg No.	36	0843	36
	4 3	OF .	1. Decedent's Name (First, Middle, Last)						2. Date of De Month	Day	Year	3. Time of	Death
	Physicia /Medic		Rita Catherine	Roache						Februar		2006	9:15	a.M
	Examin		4a. Facility Name (If not institution, give	street and number	r)		4b. City, To	own, or L	ocation o	of Death	4c. Cour	nty of Death		
			Brighton Gardens		la ige (In yrs. la	ast hirthday)	Rocky If Under 1		e If Under :	24 Hrs. 8. Date of Bi	rth.	9 Birth	gomery place (State of	r Foreian
	Funeral Director		5. Social Security Number 6. Se 1579-12-7723	х]м 2[¥F ′. ́́	.ge (iii yis. ii 88	Yrs.	Months		Hours	Min. (Month, D) Feb. 2	, Year) 1918	Ne	w York	, or olgin
34.35°°	~ *		Usual Residence of Decedent											
	how	_	10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside Cit	
	Ba-f s	cto	Maryland Montgome	ery	Si	lver S					10g. Citizen o	4) 4 / 5 - 4 / 6 - 4		
	vith th	Dire	10e. Street and Number 3330 North Leisure	world F	5v IS	#116	10f. Zip C	ode 2090	6		•	USA	intry !	
	within 72 hours after death with the Maryland ane. than 'traturel', or itema 23s or 28s-f show he Mavical Exeminer must be mollified at	Funeral Director	11. Marital Status	12. Was Deceder						gin? (Specify Yes or N		lace - Amer		
10	ter d	Fun	1 Never Married 2 Married	Armed Forces	<u>i</u> ?					gin? (Specify Yes or N i, Puerto Rican, etc.)		Black, White cify: Whi		
036	urs a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates	:		1 ☐ Yes 2	∆j4No	Specify:		Spe	sify: WIII		
21215-0036	72 ho natur	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)		(Give	dent's Usual kind of work	done du	ion ring mos	t of working	16b. Kind of	Business/li	ndustry	
121	han han	mpi	Elementary/Secondary (0-12)	College (1-4o	r 5+)		<i>DO NOT</i> use emaker	retirea)			0	wn Ho	me.	
2	Hygie Ther th		12 17. Father's Name (First, Middle, Last)			HOINE	emaker	1	8. Mothe	er's Name (First, Middle			ine .	
and	d be i	o Be	Joseph McCarthy						Ma:	rgaret Flah	nerty			
Maryland	shoul nd Me mark	6	19a. Informant's Name/Relationship (7)	уре, Print)						er or Rural Route Numb				
Ž	alth a 27 is		Philip L. Roache,	Jr./Hush	oand	3330) N. L	eisu:	re W	orld Blvd.	#116,	Silv	er Spri	ing,MD
J.	of Her		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Romoval from Stat	_ 00	face of Dispo emetery, crea	matory or oth	ner place)	,	Date Marrich 3	20c. Locatio	in - City or T	Fown, State	
im	Page Internal		4 □ Donation 5 □ Other (Specify		Gate	e of Hea	iven Cen	netery	7	March 3, 2006	Silver	Spri	ng, Maı	ryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23s or 28s-1 show any injury or other traumatic avant, the Mardical Examiner must be multiled at once.		21. Signature of Funeral Service Licen:	9		F7	Name and Cancis O Uni	J. (Coll	ins Funera Blvd, W, S	l Home ilver S	Inc pring	, MD 20	901
1			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	one cause on each	line.					cardiac or respiratory	arrest,		Approximate Interval Bette Onset and I	ween Death
	Physician /Medical		disease or condition resulting in death)	a. Viral I	Respir as a consequ		Infec	tion					48 Hot	ırs
Fig	Examiner	8		Obstruc			Diseas	e				1	10 Yea	ars
*		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		as a consequ	uence of):								
	ate be executed hysician and he burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c										
760,	be exectan a	Ë	resulting in death, cast	Due to (or a	as a consequ	uence or):								
687	physic the b	dicai	•	d										
9 ×	leath certificat attending phy I for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcon	ne of pregna	incy					23d.	Date of deli	ivery	
Вох	death atten	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	1 ☐ Live birth 4 ☐ Pregnant	at time of de		⊒Ectopic pre ⊒ Other <i>(spe</i>					Month	Day	Year
0	t the c by the achec	hysi	9 Unknown	9□ Unknown	1					_				
σ,	equires that the de een signed by the a tould be detached t		Part II. Other significant conditions of			-		use giver	n in Part I		tobacco use o		_	
ord	w require been sig	ted	Aortic and Mitra	l Valve .	Insuff	icieno	zy			1	Yes 3434N	5 3∐Pn	obably 4 🔲	Unknown
Records,	aw las by	Completed by								24a. Wa aut	s an 24 opsy formed?	tb. Were au prior to d death?	topsy findings completion of c	available ause of
<u> </u>	Th ate pag	S									2K No	1 Yes	2 🗌 No	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:						e of Death Check only				
of	Phys this ral di	2	1 Yes 2X No 27. Manner of Death	1 🗆 Inpa		ER/Outpatie		Bc. Injury Work		ursing Home 5 Re	how injury oc		cify)	
on	tending (leath. tor: After the funer	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of I (Month,	Day Year)	Injury	м		? 'es 2 🗌	No				
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of	Injury - At he etc. (Specif	ome, farm, st	reet, factory,	, office			(Street and No	ımber or Ru	ıral Route Nun	nber,
	spital nours a neral C	ai Ce	29a. Certifier 1 Certifying Ph	y sician: To the be	st of my kno	wledge, dea	th occurred a	at the time	e, date ar	nd place, and due to th	e cause(s) and	i manner as	stated.	-)
	tha Hc thin 24 the Fu mpletel	Medical	(Check only 2 Medical Examone) 29b. Signature and little of certifier	and manner		LUON ANO/OF I	_	License		ath occurred at the time			h. Day, Year)	
			1	$\sim \sim$) >	(0)	Di	308	400	Mar	ch 3,	2006	
	10		30. Name and address of person who	completed cause of	of death (Item	n 23a) (Type	Zing .	400	,00	7 7				
						kvill	Pike	, #4	.09,	Rockville,	MD 208	52		
	St Regist	ate rar	31. Date filed (Month, Day, Year) MAR 0 6 2	006 32 109	istrar's Signa	ature	rester							

Melonie L. Richardson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06-01704 Unpend Amend item#1,m23a-b, 27, perME, C854, 4/12/06 TT State of Maryland / Department of Health and Mental Hygiene NIM 1 - For State Registrar 08437 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Year Melaine Lynn Richardson /Medical March 9 2006 0530 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Clinton
Inder 1 Year | If Under 24 Hrs. | 8. Date of Birth
Other Days | Hours | Min. | Sept. | 14, Southern Maryland Hospital Center Prince George's 5. Social Security Number If Under 1 Year Months Days 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1962 578-78-0450 1 M 2 √F Months Director 43 Washington, Usual Residence of Decedent deeth with the Maryland 10a. State permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Marylan Department of Health and Mentai Hygiene. Important: if item 27 is marked other than "naturel", or itema 23a or 28a-f show eny injury or other treumatic event, the Modical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director D.C. 1X Yes 2 No N/A Washington 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 900 Emerson Street, N.W. 20011 Funerai United States 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 21 No Specify: 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Social Worker D.C. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Guy B. Richardson 2 Josephine O. Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherese Melton (Daughter) 900 Emerson Street, N.W., Washington, D.C. 20011 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rock Creek Cemetery 3/20/06 Washington, D.C. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McGuire Funeral Service 7400 Georgia Ave. N.W., Wash. D.C. notre tho pour 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Cardiac arrhthymia /Medical Due to (or as a consequence of): Examiner Cardiac hypertrophy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner ed by the ettending physicien and detached for use as the burial-transit or Attending Physicien: The law requires that the death certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death Month Dav 5 Other (specify) the th 9 Unknown ģ cete hes been signed pege 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? this certificete 2 No 2 No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) MXYes 2 No ဥ 20 ER/Outpatient 3 DOA funerai 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 2 ☐ Accident 1 ☐ Yes 2 ☐ No the within 24 hours ener con-Director: 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical To the 29b. Signa 29c. License number 29d. Date signed (Month, Day, Year) OCME March, 10, 2006 address of person who completed cause of death (Item 23a) (Type, Print) non 111 Penn Street Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) State 🕵 Registrar's Signature Registrar 15 2006

			For State Registrar	State of M		partment of Healt		al Hygiei Reg.	0000	18438
			1. Decedent's Name (First, Middle, Las	t)				te of Death	Day Year	3. Time of Death
L	Physicia /Medic		Margaret	С.	Scarborou	gh	Marc	ch 3,	2006	8:00 P M
	Examin		4a. Facility Name (If not institution, give		r)	4b. City, Town, or Locati	ion of Death		4c. County of Dea	
			1212 Swan Creek F			Fort Wash			Prince Ge	
	Funeral Director		5. Social Security Number 6. Se 572-24-6417	DM 21∆ F 7.A	kge (In yrs. last birthda Yrs.	Months Days Hou	irs Min. (Mo	te of Birth onth, Day, Ye Ch 31,	1922Vir	thplace (State or Foreign ountry)
			Usual Residence of Decedent				μιατ	CII JI,	TATALL	} ΙΠΙ α
	rylan	_	10a. State 10b. County		10c. City, Town or	ocation				10d. Inside City Limits 1 ☐ Yes 2 No
	Ba-f s	cto	Maryland Prince (leorge's	Fort	Washington				
	vith the	Directo	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	ountry?
	sath v	era	1212 Swan Creek F	12. Was Deceden	t Ever in II S 12	20744 . Was Decedent of Hispanic	Origin? (Specify V	as or No-	U.S.A.	oriega Indian
	ter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces	?	If Yes, specify Cuban, Mex	cican, Puerto Rican,	etc.)	Black, Whi	
99	urs al	þ	3 ☐ Widowed 4 🂢 Divorced	If Yes, Give Year or Dates		1 ☐ Yes 2 No Spe	city:		Specify: Wh	ite
1215-0036	filed within 72 hours after death with the Maryland Hygiene. Kiter then "naturel", or items 23e or 28e-f show wit, Ite Madical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed}	16a. Dec	edent's Usual Occupation re kind of work done during	most of working	16b	. Kind of Business	/Industry
7	ithin ne.	nple	Elementary/Secondary (0-12)	College_(1-4or	r 5+)	DO NOT use retired)			_	
2	filed w Hygier sther th	CO	47 Falbarda blama (Finsk billiddin 1 and)	4	Sale	s Representa	tive lother's Name (First,	Adielella Adais	<u>Furnitu</u>	re
Baltimore, Maryland 21	be d	Be	17. Father's Name (First, Middle, Last) Thomas Dewey Cole				llie Rose			
Ē	is 1 end 2 should of Heelth and Men itam 27 is marke other treumatic	ဥ	19a. Informant's Name/Relationship (7	<u> </u>	19b. Ma	ling Address (Street and Nu				Zin Code)
<u> </u>	end 2 sho selth and n 27 is m		Dorothy C. Rideout			Maury Road,				
ā,	f Hee fam (20a. Method of Disposition	7 01300		position (Name of ematory or other place)	Date	20c	Location - City or	
Ě	0 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			n Memorial Pa	ark 2006	9, P	cince Geo	orge, Virgini
	permit. Pag Department Important: b any injury o once.		21. Signature of Funeral Service Licen			22. Name and Address of F		_	Washingt	
ñ	Paris de la compansión		Vacl A. Well	Son		untt Funeral				
П			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that cause	ed the death. Do not e					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	A	tero releas	ni asuni	oursalm	, Oils	ATE.	Onset and Death
	/Medical		resulting in death)	Due to (or a	s a consequence of):	THE OF THE	00/10-170	10100		Trees
П	Examiner		Sequentially list conditions,	b						
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence of):					
	and and il-tran	хап	that initiated events resulting in death) Last	c. Due to (or a	s a consequence of):		_		_	
8/60	certificate be executed ding physicien and use as the burial-transit	dical E		`						
89	ficate phy: as the	edic		O						
Вох	eath certific attending p	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom					23d. Date of de	livery
	D 0 0	Physician/Me	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)			☐ Ectopic pregnancy ☐ Other (specify)			Month	Day Year
o.	at the de by the stached	Phys	9 🗆 Unknown							
Ś.	The taw requires that the ite has been signed by th bage 2 should be detache	ρ	Part II. Other significant conditions co	intributing to death	but not resulting in the	underlying cause given in P	art I. 23	. /		o the cause of death?
5	v require been si should b	Completed	<u> </u>					1 Seres	2 □ No 3 □ P	robably 4 Unknown
ec	e faw has b	nple					24	la. Was an autopsy	prior to	utopsy findings available completion of cause of
							10	performed ☐ Yes 2		s 2□ No
Vital Records,	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Other	Place of Death (Chec			
	Attending Physician: r death. sctor: After this certificator, y the funeral director.	5	1 ☐ Yes 2 ☐ No 27. Manyner of Death	1 ☐ Inpai		#L	Nursing Home 5		e 6 □Other (Speniury occurred	ecify)
0	ding I th. : After s funer	tlor	1.△Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	Say Year) Injury				.,,	
Division of	r Attendi ler death. Irector: A n by the fu	Ifica	3 Suicide 6 Could not be	28e. Place of I	njury - At home, farm,	street, factory, office				lural Route Number,
á	P et la	Certification:	4 Homicide	building, e	etc. (Specify)		Cit	ty or Town, S	tate)	
	To the Hospital within 24 hours a To the Funeral I completely filled		29a. Certifier Certifying Ph	ysicien: To the bes	st of my knowledge, de	ath occurred at the time, date	e and place, and du	e to the cause	e(s) and manner a	s stated.
	the H in 24 the Fi	edical	one)	and manner s	stated.	investigation, in my opinion,	death occurred at tr	te ume, date	and place, and du	e to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of continer			29c License numb			Date signed (Mon	
r	1		1			101798	/		0/6/06	
1	RX		30. Name and address of person who o	completed cause of	death (Item 23a) (Typ	e, Print)	YUD F	= Varl	horda)	14) 20744
	Sta	10	31. Date filed (Month, Day, Year)	32. R	strar's Signature	4110N 10	105	10011	y y	1500/17
	Registr		MAR 0 6	2006	eve &	Goarle				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08439 State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ^{Day}2006 Year March 1. **Physician** 17:27 Ernest Stones John /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Deale 6048 Melbourne Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Manners | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | National Property | Nati 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**X**XM 2□ F 81 578-26-4401 Yrs. Virginia Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28e-f show traumatic event, the Medical Examinar must by notified at 1 Tyes ZXX No Deale Director Maryland 1 4 1 Anne Arundel 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code with USA 20751 6048 Melbourne Avenue Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Ves 2 □ No If Yes, Give Year or Dates: WW III Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed by WII 3XXWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter h and Mental Hygie 7 is marked other i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ora Rebecca Royston Walter Ernest Stones ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11236 Old Ridge Road Doswell, Virginia Health Item 27 Billie Jean Clayton / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Depertment of H Important: If its any injury or ot once. 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 03/04/2006 Edgewater, Maryland Kalas Crematory 21. Signature Ineral Service Licensee 22. Name and Address of Facility 2. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 20/45 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death iosclerotic Heart Disease Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner nding physicien end use as the burial-transit or Attending Physician: The lew requires that the death certificate be executed erten Division of Vital Records, P.O. Box 68760, Physiclan/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably

A Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an XX No 1 Tes 2 No cartificate 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) XXYes 2 No Certification: To this After this funeral c 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 🖾 Natural 5 Pending death. 1 Tyes 2 No investigation 2 Accident To the Hospitel or Attency within 24 hours after death To the Funerel Director: the 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Af home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 D0006054 March 3, 2006 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William P. Jones. MD 695 America Ct. Davidsonville, MD 21035

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 0 6 2006

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2006 Year March 4, Physician Stottlemyer Helen 11:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Laure 1 Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□M 2**X**F 579-09-3824 88 Yrs Director Mar. 29,1917 Missouri Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location r 28a-f show 10a State 10d. Inside City Limits 1 XYes 2 ☐ No Director Florida Lee North Fort Myers 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with or items 23a or ò 16250 Bay Pointe Blvd 33917 USA Pages 1 and 2 should be filed within 72 hours after deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: þ Specify: White 3 Widowed 4 □ Divorced "naturel" Completed traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other then Elementary/Secondary (0-12) College (1-4or 5+) License Examiner Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ie marked of Henry Schwind Nellie Bryson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Michael Stottlemyer/Son 5236 Flamingo Dr. St. James City, FL 33956 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If its eny injury or ot once. 1 ■ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/10/2006 Frederick, MD Utica Cemetery 21. Signature of Funeral Service Lice 22. Name and Address of Facility Stauffer Funeral Home, PA ell 104 E. Main Street Thurmont, MD 21788 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** 48 Hours Pneumonia /Medical Due to (or as a consequence of) Examiner 48 Hours Sepsis Sequentially list conditions, any, leading L. immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physicien and s the burial-translt To the Hospital or Attending Physician: The law requires that the death certificate be executed Renal insuffiency Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Septic Shock 48 Hours as the attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2X No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached t 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 21 No 3 ☐ Probably 4 ☐ Unknown been si should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 2 1 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 XNo 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending 1 Natural investigation 1 ☐ Yes 2 ☐ No 2 Accident d in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter d To the Funeral Direct completely filled in by 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060345 March 6, 2006 Juna asser 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10724 Little Patuxent Parkway, Columbia, MD 21004 Kaiser Ahmad 31. Date filed (Month, Day, Year) 32. Raistrar's Signature State MAR 0 7 2006 Registrar

			1 State	State of Marylan	Co	tificate of L	Dooth	mornia. Try	aleile 1 1	6 08441
	en en en en en en en en en en en en en e		Registrar 1. Decedent's Name (First, Middle, Last	*)	Cei	lilicale of L	Jeann	2. Date of De.	Reg. No.	2 Time of Dooth
7	Physici	an	D033335	,				Month	Day	Year 3. Time of Death
	/Medic		DONALD R 4a. Facility Name (If not institution, give	ALPH SMITH	JR	4b. City, Town, or	Location of Death	MARCH	4 2006 4c. County	/,08a
	Examin	er								
20	Funeral		Frederick Memoria 5. Social Security Number 6. Se		last birthday)	If Under 1 Year	ederick If Under 24 Hrs.	8. Date of Birt		ederick
	Director		220-54-2586	M 2□F 55	Yrs.	Months Days	Hours Min.	(Month, Da April 1	y, Year)	Birthplace (State or Foreign Country)
	0		Usual Residence of Decedent					Whiti I	4,1930	Maryland
	nylan how	_	10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	e Ma	cto	Maryland Freder	ick Fre	derick					1X Yes 2 □ No
	ith th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Country?
	within 72 hours after death with the Maryland ene. than "naturat", or iteme 23s or 28s-f ehow he Medical Examinar must be notified at		2104 BC Whitehall	Road		217	02	1	United	States
	r dez	by Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?		Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (S n. Mexican, Puert	pecify Yes or No	14. Rac	e - American Indian, ck, White, etc.
36	or it	Y.F.	1 Never Married 2 Married	1 ☐ Yes 2X No If Yes, Give		1 ☐ Yes 2 ☒ No	Specify:		Specify	
21215-0036	urat	D.	3 Widowed 4 Divorced	Year or Dates:					Specify	Black
<u>γ</u>	"nat	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	(Give	ient's Usual Occupa kind of work done of	during most of wor	king	16b. Kind of Bu	usiness/Industry
12	withir ane. Ithen	E P	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired,			1.	1 0
	Hygie ther nt,	ပိ	17. Father's Name (First, Middle, Last)	2	You	h Counse	LOT 18. Mother's Nan	on /First Middle		d Government
Maryland	ntal hed od od o	Be		h C.						
2	hould d Me nark natio	2	Donald Ralph Smit		405 14 1		Maryland			
Ma	12 sl h and 7 ts r traur	0.1			100	ig Address (Street a				
	1 and Healt em 2 ther		Regina A. Smith/ S		9981 T	Suscarora sition (Name of	Road, R.	andallst Date		21133 City or Town, State
סר	t of it		1 ⊠ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, crer	natory or other place	13/8/	2006	20c. Location -	City or rown, State
ξï	t. Partmer		4 Donation 5 Other (Specify)		sthaver	Memoria:	l Garden	3	Frederi	ck, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or iteme 23a or 28a-1 ehow any injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Juneral Service Licens	00	Şt	. Name and Addres auffer Fi	is of Facility uneral Ho	ome P. A		Maryland 21702
	40240		Soul D	upu	16	21 Opossi	ımtown P	ike, Fre	derick,	
1			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ne cause on each line.	th. Do not ent	er the mode of dying	g, such as cardiad	or respiratory ar	rest,	Approximate Interval Between
34	Physician		Immediate Cause (Final disease or condition	a He	mon	Roger	0			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq			lenor			
7	- Addition	_	Sequentially list conditions,	b. PV	12701	& Cot	Klnor	ha		
1.8	be #is	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	juence of): /					
	and I-tran	хап	Cause (Disease or injury that initiated events resulting in death) Last	c						
	icate be executed physician and s the burial-transit	ŭi l								
60,	lysi ysi	=	resulting in deathy Last	Due to (or as a conseq	juence of);					
8760,	S 5 =	dicai	Tosulaing in dodain/ Last	Due to (or as a conseq	juence of);					
x 68760,	ertifica ding ph	edicai	IF FEMALE:	d						
	ath certifica attending ph for use as th	edicai	IF FEMALE:	d	ancy	Ectopic pregnancy				e of delivery
Box (ne death certifica the attending ph thed for use as th	edicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	d	ancy	Ectopic pregnancy			23d. Dat	
P.O. Box (hat the death certifica od by the attending ph detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	d	ancy Il death 3 [leath 5 [Other (specify)	n in Day!	220 Did to	Moi	nth Day Year
P.O. Box (ires that the death certifica signed by the attending ph I be detached for use as th	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	d	ancy Il death 3 [leath 5 [Other (specify)	on in Part I.		bbacco use contr	nth Day Year ribute to the cause of death?
P.O. Box (by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	d	ancy Il death 3 [leath 5 [Other (specify)	on in Part I.		bbacco use contr	nth Day Year
P.O. Box (s law requires that the death certifica has been signed by the attending ph e 2 should be detached for use as th	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	d	ancy Il death 3 [leath 5 [Other (specify)	n in Part I.	1 □ Y 24a. Was autop	obacco use control es 2 1 No	ribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available brior to completion of cause of
Records, P.O. Box (: The law requires that the death certifica cate has been signed by the attending ph page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	d	ancy Il death 3 [leath 5 [Other (specify)	n in Part I.	1 □ Y	obacco use control /es 2 1 No an 24b. V	ribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available
Records, P.O. Box (ician: The law requires that the death certifica settificate has been signed by the attending ph ector, page 2 should be detached for use as the	Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions co	d	ancy Il death 3 [leath 5 [Other (specify)	26. Place of Dea	1 🗆 Y	obacco use control es 2 No an 24b. V sy med? 2 No 1	ribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of leath?
Records, P.O. Box (ysician: The law requiscertificate has been director, page 2 should	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions co	d	ancy Il death 3 [leath 5 [ulting in the uniting	Other (specify)	26. Place of Dea	1 🗆 Y	obacco use control obacco use co	nth Day Year ribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of leath? Yes 2 No
Records, P.O. Box (ysician: The law requiscertificate has been director, page 2 should	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions co	d	ancy Il death 3 [leath 5 [other (specify) Inderlying cause give t 3 DOA Other	26. Place of Dea	24a. Was autop performed to the Check only of the Check only of the Check only of the Check only of the Check only of the Check only of the Check only of the Check only of the Check only of the Check only of the Check on	obacco use control obacco use co	ribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? Yes 2 No
Records, P.O. Box (ding Physician: The law requent After this certificate has been funeral director, page 2 should	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions co	d	ancy Il death 3 Leath 5 Leath 5 Leath 5 Leath 5 Leath 1 Leath	t 3 DOA Other 28c. Injury Work M 1 Y	26. Place of Dea	24a. Was autop performed to the Check only of the Check only of the Check only of the Check only of the Check only of the Check only of the Check only of the Check only of the Check only of the Check only of the Check on	mobacco use control /es 2	ribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? Yes 2 No
ision of Vital Records, P.O. Box (utending Physician: The law requ death. ctor: After this certificate has been y the funeral director, page 2 shouli	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions co	d	ency Il death 3 [] Jeath 5 [] Sulting in the unitin	t 3 DOA Other 28c. Injury Work M 1 Y	26. Place of Dea or: 4 □ Nursing H at	24a. Was autop performent of the Check only of the Check only of the Check only of the Check only of the Check only of the Check only of the Check only of the Check only of the Check only of the Check only of the Check on	mobacco use control /es 2	ribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? Yes 2 No
ision of Vital Records, P.O. Box (utending Physician: The law requ death. ctor: After this certificate has been y the funeral director, page 2 shouli	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnat Compared to the pregnant at time of dependent of the pregnant at time of dependent of the pregnant at time of dependent of the pregnant of t	ER/Outpatien 28b. Time of Injury ome, farm, str.	other (specify) aderlying cause give t 3 □ DOA Other 28c. Injury Work M □ Y eet, factory, office	26. Place of Dea In 4 ☐ Nursing H at ? es 2 ☐ No	24a. Was autop performent of the control of the con	obacco use control (es 2 No an 24b. V sy med? 2 No lence 6 Other low injury occurr Street and Number m, State)	ribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available brior to completion of cause of death? Yes 2 No er (Specify) ed
ision of Vital Records, P.O. Box (utending Physician: The law requ death. ctor: After this certificate has been y the funeral director, page 2 shouli	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d	ER/Outpatien 28b. Time of Injury owne, farm, str	t 3 DOA Other (specify) 28c. Injury Work M 1 Y eet, factory, office	26. Place of Dea	24a. Was autop performent of the Check only only only only only only only only	obacco use control (es 2 No an 24b. V sy med? 2 2 No lence 6 Other low injury occurr Street and Numb.	nth Day Year ribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of leath? Yes 2 No er (Specify) eed
ision of Vital Records, P.O. Box (utending Physician: The law requ death. ctor: After this certificate has been y the funeral director, page 2 shouli	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnat Compared to the pregnant at time of dependent of the pregnant at time of dependent of the pregnant at time of dependent of the pregnant of t	ER/Outpatien 28b. Time of Injury owne, farm, str	t 3 DOA Other (specify) 28c. Injury Work M 1 Y eet, factory, office	26. Place of Dea 17: 4 □ Nursing H at 17: 17: 18: 2 □ No 19: date and place 19: dinion, death occu	24a. Was autop performent of the control of the con	bbacco use control yes 2 No an 24b. V sy med? 22 No lence 6 Other low injury occurr Street and Number cause(s) and madate and place, a	nth Day Year ribute to the cause of death? 3 □ Probably 4 □Unknown Were autopsy findings available prior to completion of cause of leath? □ Yes 2 □ No er (Specify) eet er or Rural Route Number, nner as stated, and due to the cause(s)
ision of Vital Records, P.O. Box (utending Physician: The law requ death. ctor: After this certificate has been y the funeral director, page 2 shouli	edical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d	ER/Outpatien 28b. Time of Injury owne, farm, str	t 3 DOA Other (specify) t 3 DOA Other 28c. Injury Work M 1 Y eet, factory, office 1 occurred at the tim restigation, in my op	26. Place of Dea T 4 Nursing H at ? /es 2 No e, date and place pinion, death occu	24a. Was autop performent of the Check only only only only only only only only	bbacco use control yes 2 No an 24b. V sy med? 22 No lence 6 Other low injury occurr Street and Number cause(s) and madate and place, a	nith Day Year ribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of leath? Yes 2 No er (Specify) eed
ision of Vital Records, P.O. Box (utending Physician: The law requ death. ctor: After this certificate has been y the funeral director, page 2 shouli	edical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnat 1	ER/Outpatien 28b. Time of Injury owne, farm, str. bwledge, death tition and/or instruction	t 3 DOA Other (specify) t 3 DOA Other 28c. Injury Work 1 Yest, factory, office a occurred at the tim vestigation, in my op	26. Place of Dea 17: 4 □ Nursing H at 17: 17: 18: 2 □ No 19: date and place 19: dinion, death occu	24a. Was autop performent of the Check only only only only only only only only	bbacco use control yes 2 No an 24b. V sy med? 22 No lence 6 Other low injury occurr Street and Number cause(s) and madate and place, a	nth Day Year ribute to the cause of death? 3 □ Probably 4 □Unknown Were autopsy findings available prior to completion of cause of leath? □ Yes 2 □ No er (Specify) eet er or Rural Route Number, nner as stated, and due to the cause(s)
ision of Vital Records, P.O. Box (utending Physician: The law requ death. ctor: After this certificate has been y the funeral director, page 2 shouli	edical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnat 1	ER/Outpatien 28b. Time of Injury owne, farm, str. bwledge, death tition and/or instruction	t 3 DOA Other (specify) t 3 DOA Other 28c. Injury Work 1 Yest, factory, office a occurred at the tim vestigation, in my op	26. Place of Dea T 4 Nursing H at ? /es 2 No e, date and place pinion, death occu	24a. Was autop performent of the Check only only only only only only only only	bbacco use control yes 2 No an 24b. V sy med? 22 No lence 6 Other low injury occurr Street and Number cause(s) and madate and place, a	nth Day Year ribute to the cause of death? 3 □ Probably 4 □Unknown Were autopsy findings available prior to completion of cause of leath? □ Yes 2 □ No er (Specify) eet er or Rural Route Number, nner as stated, and due to the cause(s)
ision of Vital Records, P.O. Box (utending Physician: The law requ death. ctor: After this certificate has been y the funeral director, page 2 shouli	Medical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnat 1	ER/Outpatien 28b. Time of Injury ome, farm, striy) owledge, death tition and/or important and and and and and and and and and and	t 3 DOA Other (specify) t 3 DOA Other 28c. Injury Work 1 Yest, factory, office a occurred at the tim vestigation, in my op	26. Place of Dea T 4 Nursing H at ? /es 2 No e, date and place pinion, death occu	24a. Was autop performent of the Check only only only only only only only only	bbacco use control yes 2 No an 24b. V sy med? 22 No lence 6 Other low injury occurr Street and Number cause(s) and madate and place, a	nth Day Year ribute to the cause of death? 3 □ Probably 4 □Unknown Were autopsy findings available prior to completion of cause of leath? □ Yes 2 □ No er (Specify) eet er or Rural Route Number, nner as stated, and due to the cause(s)

CR 8) 10a

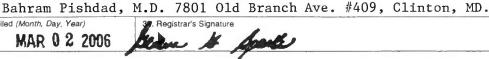
Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar 31. Date filed (Month, Day, Year) MAR 0 2 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29c. License number D 51520

29d. Date signed (Month, Day, Year)

February 28, 2006

State of Maryland / Department of Health and Mental Hygiene 08443 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** March 4, 2006 10:35 PM Theresa Eleanor Sutton /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9525-B North Laurel Road Howard Laurel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 1□M 2XF 83 Feb 17, 1923 Director 005-16-4429 Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ne 23a or 28a-f show must be notified at 1 ☐ Yes 2 XNo Maryland Howard Laurel Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 20723 USA 9525-B North Laurel Road death Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) iteme 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, rthan "natural", or iten Black, White, etc. filed within 72 hours after Hygiene. 1XXes 2 No If Yes, Give Year or Dates: 1943-46 1 Never Married 20 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker ith and Mental Hygier 27 is marked other the traumatic event, the 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Elizabeth Agnes Murray Henery Jed Bridges 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Heath ar Important: if item 27 is any injury or other trau 9525-B North Laurel Rd. Laurel, MD 20723 Robert John Sutton/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 7. 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2006 Beltsville, Maryland 21. Signatur of Funeral Service License Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a Chronic Obstructive Pulmonary Disease Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): g physicien and as the burial-transit Examin Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medicai attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🎇 No Day Month Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signated should be 1 Yes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed? certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home SP Residence 6 Other (Specify) 1 ☐ Yes 2X No this After this funeral of 28c. Injury at Work? 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Medical Certification: 5 Pending 1 X Natural death. 1 □ Yes 2 □ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D TC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and titte of certifier 29d. Date signed (Month, Day, Year) 29c. License number D D55810 March 6, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 4801 Dorsey Hall Drive Suite 201 Ellicott City, MD 21042 Jyothi Rao-Mahadevia. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Liker MAR 07 2006 Registrar

Registrar

State of Maryland / Department of Health and Mental Hygiene

			State of Marylan	•	ificate of			Reg. No.	08445
ì	Physician	Decedent's Name (First, Middle, Last, PASQUALE SANTI)					2. Dete of De Month	ath Day Year	3. Time of Death
1	/Medical Examiner	4a Fecility Neme (If not institution, give				4b. City, Town, or	March Location of Death	02 2006 4c. County of Dee	1:30 PM
di-	Examiner	Shady Grove Nursi				Rockvill	e	Montgomer	ry
	Funeral Director	5. Social Security Number 6. Sec 125 . 50 . 9475			If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	th y, _{Year)} 9. Bir Co 20 , 1909 Ita	thplace (State or Foreign ountry) 11y
	pug *	Usuel Residence of Decedent 10a. State 10b. County	10c. Cit	v. Town or Loca	ition				10d. Inside City Limits
	Maryle 4 eho 10 et	Maryland Montgome		orth Po					11∑ Yes 2 □ No
	rect	10e. Street end Number	,		10f. Zip Code			10g. Citizen of What Co	ountry?
	th wit	15344 Falconbridg	e Terrace		20878			U.S.A.	
020	poemit. Pagas 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If then 27 is marked other than "naturel", or items 23e or 28e-fehow many injury or other traumatic event, its Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Dates:		as Decedent of H Yes, specify Cuba Yes 2KI No	lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No to Rican, etc.)	- 14. Race - Ame Black, Whi Specify: Whi	te, etc.
2-0	72 hg	15. Decedent's Edu (Specify only highest grede	cation e completed)	16a. Deceder (Give ki	nt's Usual Occup nd of work done	ation during most of wo	rking	16b. Kind of Business	/Industry
Maryland 21215-0020	uld be filed within 72 hou Mental Hygiene. rked other than "nature ritic event, the Medical E. To Be Completed	Elementary/Secondary (0-12) 5th	College (1-4or 5+)		o <i>not</i> use retire: :1der	1)		Iron Wor	rk
힏	be filed at other event, Be C	17. Father's Neme (First, Middle, Last)				18. Mother's Nar	me (First, Middle,	Maiden Surname)	
<u>ylaı</u>	should b and Ments marked umatic •						ina Spi		
Mar	12 sh h and h and is m traum	19a. Informant's Name/Relationship (Ty		1	•			er, City or Town, State,	
<u>စ</u> ်	1 and Health em 27 other tr	Adelfina Santini/ 20a. Method of Disposition	20b. F	Place of Disposit	4 Falco: tion (Name of tory or other place		Date	OTTH POTOMS 20c. Location - City or	
Baltimore,	Pagas nant of I	1 ⊠ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	t Cemete		03/06 2006	Washington	, D.C.
Balt	pemit. F Departms Importan any injur phoe.	21. Signature of Funeral Service License	P	HIN		LDI FUNE			ng, MD 20904
		23a. Pert1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the deat						Approximate Interval Between
1	Physician /Medical	Immediate Cause (Final disease or condition	A	Vance		em (-i			Onset and Death
ı	Examiner	resulting in death)	Due to (c	or es a conseque		,			1
	ficate be executed sphysician and is the bunal-transit edical Examiner	Sequentially list conditions,	Due to (c	r as e conseque	ance of):				
68760,	tificate be executed g physician and as the burial-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events	J						1
	= 000	resulting in death) Last		r as a conseque	ince of):				
. Box	nat the death certing by the attending letached for use a Physician/M		l						
0	he dear the a	Part II. Other significant conditions con	tributing to death but not resi	ulting in the und	erlying cause giv	en in Part I.			e to the cause of death?
, P.O.	es that the death cer igned by the attendin be detached for use by Physician/A						10	Yes 2 ØNo 3 □ P	robably 4 ☐ Unknown
Division of Vital Records,	requir						24a. Was perfo	med?	Were autopsy findings available prior to completion of cause of death?
ž	nysician: The law nis certificata has i I director, page 2 s To Be Compl						103	res 2kino	1 ☐ Yes 2 ☐ No
ita I	stan: ector, p	25. Was case referred to medical examiner?					ath (Check only o	one)	
5	- 02	1 ☐ Yes 2 ☐ No		ER/Outpatient 28b. Time of	3□ DOA Oth	4 11 Nursing F		dence 6 Other (Spe	ncify)
5	Attending Physician: r death. setor: After this carlifice by the funeral director, iffication; To Be (1 ☑Naturel 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Injur Wor M 1 🗆	k? Yes 2 □ No	200. Describe i	low injury occurred	
DIVISI	To the Heaptal or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di Medical Certification: TC	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stree y)	t, factory, office		28f. Location (3 City or Tou	Street and Number or R vn, State)	ural Route Number,
	Hospita 24 hours Funeral idetely fille idecal C	29a. Certifier (Check only one) 1 Certifying Phys	ilclan: To the best of my knowner: On the basis of examination and manner stated.	wledge, death o tion end/or inves	ccurred at the tir stigation, in my o	ne, date and place pinion, death occu	, and due to the irred at the time,	cause(s) and manner as date and place, end du	s stated. e to the cause(s)
	To th withir comp	29b. Signature and title of certifier	>		29c. Licens	e number		29d. Date signed (Mont	th, Day, Year)
	4		22	e	M	585	17	03-02	-06
	3	30. Neme end eddress of person who co	mpleted cause of deeth (Item		int)	1000	T. U.W >	03-02 0:1vv prig	SIMIS
	State	31. Date filed (Moott), Day, Year)	32 Registrer's Signa	ture 866	Mal	MVE, OUN	ICATAL R	1	7091.
	Registrar	MAR 0 6 20		OF ASSESSED	tel.				

Pham Tich Trinh Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06-01457 State of Maryland / Department of Health and Mental Hygiene Registrar Amend Item #8 per FH G853 3/24/1066 atta of Death AKG 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Pham Tich Trinh February 27, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** | Montgomery | Montgomery | Montgomery | Montgomery | Montgomery | Monts | Days | Hours | Min. | Min. | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Day | Month | Da 18927 Red Robin Terrace 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 44 586-18-2994 Director Usual Besidence of Decedent 10c. City, Town or Location 10a. State 10b. County *ou r than "naturel", or itema 23a or 28a-f ehov the Medical Examinar must be notified at Maryland Montgomery Onley Directo 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 20832 2111 Petersfield Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Auto Mechanic Mechanic Shop 3ŕd 12 should be filed w h and Mental Hygier 7 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sanh N Trinh Ba Tran Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) 11 Petersfield Place ley, Maryland, 20832 19a. Informant's Name/Relationship (Type, Print) Anthony Fu/brother-in-law ges 1 and 2 t of Health If Item 27 Onley, Maryland, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Dapartment Important: If any Injury or once. Chesapeake Crematory 03-06-2006 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility W.H. Bacon Funeral Home, Inc. 21. Signature of Funeral Service Licensee 3447 14th Street, N.W. Washington, .DC. 20010 Na 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 14 funs frad **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, 1 a.y. each g lambda cause. Enter Underlying Cause (Disease or injury that initiated events Directo (or as a consequence of) Examine certificate be executed ed by the ettending physicien and deteched for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Cher (specify) 4 Pregnant at time of death P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Duknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 Yes 2 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death [Check only one] Hospital: 1 X es 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification:

within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. Division ö To the Hospital or within 24 hours af To the Funerel D

24b. Were autopsy findings available prior to completion of cause of de 1 h?

Yes 2□ No Other: 4 Nursing Home 5 Residence XXOther (Specify) at Scene 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural Famel 8:50M and 2/27/16 1 ☐ Yes 2 🕅 No 2 Accident 3 Suicide west 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 12927 Rel 12014 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier

home Germantown, HD

At 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

3. Time of Death

9:20 A

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Day

White

1X Yes 2 □ No

O.C.M.E.

February 28, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABILICIAL 111 Penn Street, Baltimore, Maryland

31. Date filed (Month, Day, Year) MAR 0 6 2006

32. Registrar's Signature

State

			1- State of Maryland / Dep	eartment of Health and Meartificate of Death		ene () () ()	08447
			Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	Physici /Medio		BERNARD ALVIN TWIGG, Ph.D		February	Z8, 2006	10:05 a ^M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			3537 Duke Street	College Park		Prince Geo	
	Funeral Director		5. Social Security Number 6. Sex 1 7. Age (In yrs. last birthday 213-24-7220 77 Yrs.	/ If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Oct. 15,	Year) 9. Birthp Coun 1928 Mary	
	and w		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		11	Od. Inside City Limits
	Maryl f sho	tor					1∭Yes 2□No
	28a	Director	Maryland Prince George's College 10e. Street and Number	10f, Zip Code	10	g. Citizen of What Coun	trv?
	h with		3537 Duke Street	20740		U.S.A.	•
	deat ams	Funeral		Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - Americ	
9	or Ita	y Fu	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No 1946—	1 ☐ Yes 2 🖾 No Specify:	iloan, etc.)	Black, White,	
8	hours urat',	d by	3 Widowed 4 Divorced Year or Dates: 1948			Specify: Whi	
7	in 72 "nat	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of workin DO NOT use retired)	g	6b. Kind of Business/Ind	lustry
21215-0036	iene.	omp	Elementary/Secondary (0-12) College (1-4or 5+)	essor of Horticult		Iniversity of Maryland	
٥	e filed Il Hyg otha vant,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name			
<u>a</u>	uid by Menta Menta rrkad	ToE	Michael C.S. Twigg	Rosa Huf:	£		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, If a Madical Examinational be recilled at once.	Ė		ing Address (Street and Number or Rural		•	•
	and lealth m 27 har tr			Duke Street, Colle	-		
20	ges to the Hite		1 LL Burial 2 Cremation 3 Removal from State	ematory or other place)		Oc. Location - City or To	
altimore,	rtmer rtant: njury			oas Church Cem. 3/4/2		Jpper Malbor	
Ba	Depa Impo any i			2. Name and Address of Facility Gaso 739 Baltimore Ave.			
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac or	respiratory arres	st,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition a Liver Failure				Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				
	_и	-	Sequentially list conditions, if any, leading to immediate b. Cirrhosis of the Due to (or as a consequence of):	Liver			
	nsit	nine	Cause (Disease or injury				
<u> </u>	execu in and ial-tra	Examiner	that initiated events resulting in death) Last c. Due to (or as a consequence of):				
8760,	ficate be executed physician and s the burial-transit	dlcal	d				
9	ng ph as th	0	IF FEMALE:				
Вох	death certific e attending p d for use as	an/I	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	□Ectopic pregnancy		23d. Date of deliver	•
O.	0 0 0	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		Month	Day Year
٩.	res that the de signed by the a be detached t	Ph	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I	23e. Did toba	acco use contribute to the	e cause of death?
Records,	The law requires that the te has been signed by the bage 2 should be detache	d by	Diabetes; Renal Failure; Anemia	and any my deaded grown in the art.		2 No 3 Proba	
CO	w require been si should I	Completed			24a. Was an	24h Were auton	sy findings available
Re	The fav	duic			autopsy	prior to com death?	pletion of cause of
of Vital		e	25. Was case referred to medical	26. Place of Death	-	☑ No	2 🗀 No
<u>></u>	nysici lis cer direc	ToB	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Other)
0	ding Ph h. After th funeral		27. Manner of Death 1 X Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 1 Injury		3d. Describe how		
<u>S</u>	tendi death. tor: A the fu	cati	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division	or At after of Diract in by	Certification;	4 ☐ Homicide determined determined determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	Bf. Location (Stre City or Town,	et and Number or Rural State)	Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To tha Funaral Diractor: After this certifics completely filled in by the funeral director, to		29a. Certifier 1X Certifying Physician: To the best of my knowledge, deat	th occurred at the time, date and place, or	nd due to the on-	see/e) and manner as at	nted
	e Hos n 24 h na Fur	edical	(Check only 2 Medical Examiner: On the basis of examination and/or in one)	estigation, in my opinion, death occurred	d at the time, dat	e and place, and due to	the cause(s)
	To the within To the comp	Me	29b. Signature and title of control	29c. License number	290	d. Date signed (Month, E	Day, Year)
	10		· V lauffelt	D26382	Ma	arch 1, 200	6
	IVADA	,	30. Name and address of person who completed cause of death (Item 23a) (Type,	•		-	
	6/1		Marc R. Shepard, MD 4700 Berwyn Hot 31. Date filed (Month, Day, Year) 32. Ragistrar's Signature	use Road, #105, Col	lege Pa	rk, Marylan	d 20740
	Sta Registr	_	MAR 0 3 2006	badis			

	ľ	For State Registrer	State of Maryland / Dep Ce		Mental Hyg	iene eg. No. 0 0 0 8 4 4 8
Physicia /Medica Examine	al	1. Decedent's Name (First, Middle, Last) Ross Wesle 4a. Facility Name (If not institution, give st 1975 Addison Rd. S		4b. City, Town, or Location of Death District Height	1	by 24, 2006 3. Time of Death 1:30P M 4c. County of Death Prince George
Funeral Director		5. Social Security Number 6. Sex	M 2□F 7. Age (In yrs. last birthday Yrs.			
Laryland ZIZIS-UUSO 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or items 23a or 28a-f show eumatic event, he Medical Evantinat must be notified at	al Director	Maryland Prince Ge 10e. Street and Number 1975 Addison Rd. S				10d. Inside City Limits 1 127 Yes 2 □ No 0g. Citizen of What Country? United States
ours after deal	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Amed Forces? 1 孫Yes 2 □ No 1955 If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (SI If Yes, specify Cuban, Mexican, Puerti 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - American Indian, Black, White, etc. Specify: Black
6d within 72 hours all ygiene "natural", or her then "natural", or it, the Medical Evanti.	Complete	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12) 12	College (1-4or 5+) (Give	edent's Usuaf Occupation a kind of work done during most of work DO NOT use retired) ocial Worker	king	16b. Kind of Business/Industry Government
Maryland d 2 should be file th and Mental Hy R7 is marked oth treumatic event	lo Be	17. Father's Name (First, Middle, Last) Ross Wesley Troub 19a. Informant's Name/Relationship (Type)	e, Print) 19b. Mail	Goldie ing Address (Street and Number or Ru		. City or Town, State, Zip Code)
IIMOre, IV. Pages 1 and timent of Health rent: If item 27 jury or other triums.		Sandra Soto/Daug 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Re 1 □ Donation 5 □ Other (Specify) 21. Signature of Euneral Service Licensee	20b. Place of Disp cemetery, cre Metropoli	inatory or other place) Itan Crematory Marc	Date :	20c. Location - City or Town, State Alexandria, VA.
Physician		23a. Part1. Enter the disease, or compiled shock, or heart failure. List only one Immediate Cause (Final		iter the mode of dying, such as cardiac		Eral Homes Lboro Pike Lle, MD. 20747 est, Approximate Interval Between Onset and Death
/Medical le be executed /Medical Examiner e purial-transit	cai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Acute Myocardial Due to (or as a consequence of): Arteriosclerotic Due to (or as a consequence of): Due to (or as a consequence of):	: Hypertenison Car	diovascu	lar Disease
J = 00 # 1	Pnysician/medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
he law requires that he law sequires that he has been signed by the 2 should be deta	à	Part II. Other significant conditions cont	ributing to death but not resulting in the t	underlying cause given in Part I.		sacco use contribute to the cause of death?
	Be Completed	25. Was case referred to medical		26 Place of Dag	24a. Was an autops perform 1 Yes 2	y prior to completion of cause of death? I⊠No 1 ☐ Yes 2 ☐ No
\$ 4 4 4 5 F	2	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	nt 3 DOA Other: 4 Nursing H		nce 6 Other (Specify)
pital or Attending urs after death, aral Director: Afte	Certification	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of fnjury - At home, farm, st building, etc. (Specify)		City or Town	
To the Hospital or Al within 24 hours after Completely filled in by Madical Continuation (Madical Continuation)	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier	cian: To the best of my knowledge, deal er: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, evestigation, in my opinion, death occur 29c. License number 8436	red at the time, da	use(s) and manner as stated. Ite and place, and due to the cause(s) Id. Date signed (Month, Day, Year) February 28, 2006
15/1Va			1.D. 1263 Evarts St	., NE; Washington	, DC. 2	0018
State Registra	- 8	31. Date filed (Month, Day, Year) MAR 0 2 2006	2. Registrar's Signature	le		

1/1

			1 - State Registrer	te of Marylan	•	artment of H		nd Mental Hy	giene Reg. No.)6	0014	9
4			Decedent's Name (First, Middle, Last)	***************************************				2. Date of De	aath	.,	3. Time of D	eath
× **	Physici		Carlton Euge	ne Tillmar	ı			Month Februar	rv 26.	2006	1630	М
	/Medic		4a. Facility Name (If not institution, give street a			4b. City, Town, or	Location of			inty of Death		
		45 mg.	Southern Maryland Ho	spital		Clinton			Pri	ince G	eorge	
- 17	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hours	4 Hrs. 8. Date of Bi	rth	9. Birth	place (State or I	Foreign
(R)	Director		577-24-8864 ^{1XI M 2}	^{∐F} 86	Yrs.	Michals Days	Hours	Min. (Month, D.	, 1919	Wasi	n, DC.	
	p ,		Usual Residence of Decedent	100 6	. Tour or la						10d. Inside City	1.1
	aryla shov	,	10a. State 10b. County	100. 010	y, Town or Lo		0				1 1 Yes 2	
	88 -f	cto	Wash, DC		wasn	ington, D						
	or 2	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cou	intry?	
	ath v		5563 Central Avenue				0019			ted St		
	er de Items	Funeral	Am	s Decedent Ever in U	.S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origi n, Mexican,	n? (Specify Yes or No Puerto Rican, etc.)	0- 14. F	Race - Ameri Black, White		
36	rs aft	by F	If Y	¶Yes 2□No 19 es, Give ar or Dates: 19		1 ☐ Yes 2 ☒ No	Specify:		Spe	ecify: B1	ack	
ခို	within 72 hours atter death with the Maryland ene. then "naturel", or Items 23e or 28e-f show he Madical Exeminer must be notified at		15. Decedent's Education		1	dent's Usual Occupa	ation		16b. Kind o	f Business/Ir	ndustry	
7.	n "n	Completed	(Specify only highest grade comp		(Give	kind of work done of DO NOT use retired	furina most d	of working			,	
72	with liene	Eo	Elementary/Secondary (0-12) Col	llege (1-4or 5+)	Tax	Clerk			Gove	rnment		
ਰੂ	othe	Bec	17. Father's Name (First, Middle, Last)				18. Mother	s Name (First, Middle	, Maiden Sun	name)		
ılar	Alenta Alenta rked tic ev	To B	Unknown				Franc	ces Tillma	n			
Man	ad 2 sho lith and l 27 Is ma		19a. Informant's Name/Relationship (Type, Pri. Carol White/Daughter	nt)		-		or Rural Route Numb Forestvil				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23e or 28e-f show any figury or other treumatic event, the Miccical Extending or notified at ance.		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Remova	I from State	emetery, crer	sition (Name of natory or other place		Date		on - City or T		
量	it. Pa irtmen irtent: njury		4 □ Donation 5 □ Other (Specify) 21. Signuture of Funeral Service Licensee	нат	-	emorial P	- 1	rch 8, 2006		over, l	MD.	
Ba	Depa Impo any is		Mytha Dunge	MOIDIS	-			5538 Mar Forestvi		Pike D. 20	747	
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final	AA	1. /				rrest,		Approximate Interval Betwee Onset and De	en eath
	Physician /Medical		disease or condition aa.	Oue to (or as a conseq		Infor						
	Examiner		Sequentially list conditions b. A	therosc	le ro	tic Care	diove	asculor	Dist	2018		
	D ii	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ue to (or as a conseq	uence of):							
	icate be executed physicien and s the burial-transit	Examiner	that initiated events resulting in death) Last	oue to (or as a conseq	uence of):							
8760,	e be e sicien buri	dlcal E	L _d									
9	ificati g phy as the	edic										
Вох	n certific anding p use as	N/M		es, outcome of pregna		1			23d.	Date of deliv	rery	
	death	lcla	1 Ves 2 No	Live birth 2 Feta Pregnant at time of d		Ectopic pregnancy Other (specify)				Month	Day Ye	ar
о. О.	that the death certif ed by the attending detached for use as	Physician/Me	9 🗆 ONKNOWN	Unknown								
Vital Records,	Se Co	Completed by	Part II. Other significant conditions contributin	og to death but not res	alting in the u	derlying cause give	en in Part I.		tobacco use c Yes 2 □ No		the c <i>a</i> use of dea bably 4 X Un	
CO	taw require as been si 2 should b	lete	Congestive Heart	failure				24a. Was	an 24	b. Were aut	opsy findings av	/aılable
Re	iclen: The lav certilicate has rector, page 2	mo	End Stace Remain	10,000	000	Diales	1,	auto	psy ormed? 2010	prior to co death? 1 Yes	ompletion of cau 2□ No	use of
ita	slen: ertifica ctor, i	Be C	25. Was case referre to medical examiner?	13 50)		010091	26. Place o	of Death (Check only				
	Physic this ce al dire	2	1 ☐ Yes 25 No Hospital	1 K Inpatient 2	ER/Outpatien	t 3 DOA Othe	or: 4 ☐ Nurs	sing Home 5 Res	idence 6 🗆	Other (Speci	fy)	
Division of	ding 1. After funer	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	Date of Injury (Month, Day Year)	28b. Time of Injury	Work	at ? Yes 2 □ N	28d. Describe	how injury oc	curred		
ivisi	after death Dirsctor: / I in by the f	tifica	2 Suicido 6 Could not be	Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (City or To		imber or Rur	ral Route Numbe	9 <i>r</i> ,
Ω	urs af urs af erel D										**	
	To the Hospitel within 24 hours a To the Funerel (completely filled	Medical	29a. Certifier (Check only one) 1 (➤ Certifying Physician: 2 ☐ Medical Examiner: Or an	To the best of my kno the basis of examina d manner stated.	wledge, death tion and/or in	n occurred at the tim restigation, in my op	e, date and sinion, death	place, and due to the occurred at the time,	date and place	manner as s e, and due t	stated. to the cause(s)	
	To the within To the comp	×	29b. Signature and title of certifier			29c. License			29d. Date sig			
)	6		1 th To my	hylur)	P00 9	70	66	02-2	7-20	06	
R	J Va		30. Name and address of person who complete Uchechi 7. Opaig	d cause of death (Item		Print) 6188 0401	NH	66 on Hill ill, Man	1 gd	# 70	745	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 2 2006	Registrar's Signa		B			, , , , ,			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** February 26 2006 21:35 PM Nulen B. Tibbs /Medical 4b. City, Town, or Location of Death 4c. County of Death 40 Feeility Name (III not institution, give street and number) Hospital Examiner Chever1y

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Hours Min. (Month, Day, Year) Prince George's & Nursing Center 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1X M 2 ☐ F 1917 Wash., DC Nov. 11, Director 88 578-14-0040 Usual Residence of Deceden permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylend Depertment of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantinal must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a State 1 Yes 2 □ No Funeral Director Washington DC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20002 United States 440 - 15th St., N.E. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 1 Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 € Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No **Black** Specify: Completed by 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mail Clerk Government 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Emma Cromer Harry Tibbs 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Verlette Tibbs/Wife 440 - 15th St., N.E. Wash., DC 20002 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/3/2006 Ft. Lincoln Cemetery Brentwood, MD 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service Licenses 4001 Benning Rd., N.E. Wash., DC 20019 way 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock to heart failure. List only one cause on each line. Approximate interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Renal Failure Examiner Due to (or as e consequence of): Physician/Medical Examiner use es the buriel-trensit or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence ol): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Respiratory Failure ģ pege 2 should be 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? Congestive Heart Failure 1 Yes 2 K M to 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Manner of Death 1 Netural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time ol 28d. Describe how injury occurred After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours efter death.

To the Funeral Director: At completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 | Homicide the Hospital edicai (1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0026024 February 28, 2006

DHMH 16 Rev 6/95

State

Registrar

6490 Landover Rd., Landover, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Lester Miles, M.D.

31. Dete filed (Month, Day, Year)

MAR 0 1 2006

			1 _ For State	State of Mai					and M	lental H	ygiene	e e	710	201	No.
			Registrar 1. Decedent's Name (First, Middle, Last)		Ce	ertificat	e of L	Jeath			Reg. No	, UUt)	U 54	JI
Н	Physic			III 1 • 1-						2. Date of D Month	Da		ear	3. Time of	
	/Medi Examir		Margery Darrell 4a. Facility Name (If not institution, give s	Thorndike		4h City	Town or	Location of		March		006 . County of E	Dooth	12:0	2 A ^M
	Lxamii	iei	Rebecca House	,		Poto		Location of	Deatu			ntgome			
	Funeral		5. Social Security Number 6. Sex		'In yrs. last birthday	/) If Under	1 Year	If Under 2		8. Date of B (Month, L			<u> </u>	ace (State o	or Foreign
	Director		477-14-3146 Usual Residence of Decedent	M 2 X 1 F	81 Yrs.	Months	Days	Hours	Min.	July 7	7, 19	24 M	Count inne	sota	
	land ow		10a. State 10b. County	1	0c. City, Town or L	ocation							10	d. Inside Ci	ity Limits
	Many	ţo	Maryland Montgomer	y	Potomac									1 🗆 Yes	
	th the	lred	10e. Street and Number			10f. Zip	Code				10g. Cit	izen of Wha	t Count	ry?	
	23a (alc	9910 River Road			208.	54				USA				
	or dea	nue		Was Decedent Event Armed Forces?	er in U.S. 13	. Was Deced	dent of His	spanic Orig	in? (Spe	ecify Yes or N Rican, etc.)	lo-	14. Race - A Black, V			
36	s afte	by Funeral Directo	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏹 Divorced	1 ☐ Yes 2 XNo If Yes, Give		1 ☐ Yes		Specify:		, , , , , , , , , , , , , , , , , , , ,					
Ş	within 72 hours after death with the Maryland ene. then "natural", or items 23s or 28s-1 show ha Medical Examiner must be rediffed at	edk	15. Decedent's Educ	Year or Dates:	16a Dece	edent's Usua	al Occupa	tion	_		105 10	Specify: W			
215	nin 72	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed)	(Giv	e kind of wo. DO NOT us	rk done d	uring most	of workir	ng	16D. K	ind of Busine	es svinal	ustry	
2	giene giene	mo:	Clotheritary/Secondary (0-12)	College (1-4or 5+) 4	Edito	r					Pub]	lishin	g Co	ompany	ÿ
p	al Hy d oth	Be (17. Father's Name (First, Middle, Last)					18. Mother	's Name	(First, Middl					<u>'</u>
<u> </u>	Meni Meni Merike Merike	T _o	George Charles Darr							Choate					
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: If item 27 le marked other then "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examinar must be inclined at once.		19a. Informant's Name/Relationship (Typ George Lobsenz/Son	e, Print)	19b. Mail 4902	ing Address	(Street a	nd Number	ror Ruma.	≀Route Num thesda	ber, City o	r Town, Stat	е, <i>Zip</i> (Code)	
ଦ	Heal Heal tem 2		20a. Method of Disposition		20b. Place of Disp cemetery, cre							cation - City		n State	
Ë	Pages ent of nt: If if		1 ☐ Burial 2 MCremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Chesapea				200	ch 6,		svill			
=======================================	mit.		21. Signature of Funeral/Service)Licensed	0//						n Serv					
m —	80 E E 8		Dovey & He	Utt	MO1251 B										21020
9/60,	bu icie	al Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leason grown ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	onsequence of):	Egs								nterval Betw Onset and D	
200	ificate g phys	edical	d.												
O. Box	wrequires that the death certifics been signed by the attending ph should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at tim 9 Unknown	Fetal death 3	⊒Ectopic pre ⊒ Other (spe					2	23d. Date of Month	,		'ear
ري ح	The law requires that the take has been signed by the page 2 should be detached.	by Pi	Part II. Other significant conditions contri	ributing to death but n	ot resulting in the u	ınderlying ca	iuse giver	n in Part I.		23e. Did	tobacco u	se contribute	to the	cause of de	eath?
ğ	en sig	edk	- Lymphon	n4.						10	Yes 2	₽No 3□	Probab	oly 4 🗆 U	nknown
ecords,	law re as be 2 sho	Completed								24a. Was		24b. Were	autops	y findings a	vailable
<u>r</u>	sician: The lay certificate has rector, page 2	DO D								auto perfe	ormed?	death	?	oletion of ca □ No	use of
VII all E	cian: ertific actor,	Be	25. Was case referred to medical examiner?				. :	26. Place o	of Death	Check only	onol				
5	Physi this c al din	2	. C. 193 5 5 7 140	spital: 1 Inpatient	2 ER/Outpatier		A Other	4 🗌 Nurs	ing Hom	e 5 ☐ Resi	idence 6	Other (S	ресі 🗸	ssiste iving	∋id
	Jing F	0	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Time o		Bc. Injury a Work?	at	28	8d. Describe					
VISION	deatl deatl ctor: y the	flca	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury	- At home, farm, etc	M factory		es 2 No		8f. Location (Ctranton	d Alexandra a	D 1. 5	7	
Ś	s after s after al Dire	Certification:	4 Homicide determined	building, etc. (S	Specify)	eet, lactory,	Onice			City or To	wn, State)	reamber or	nurair	10010 NUMD	Θ <i>1</i> ,
	he Hospi n 24 hou he Funer pletely fill	edical	29a. Certifier (Check only one)	cian: To the best of m r: On the basis of exa and manner stated	amuration and/or in	h occurred a vestigation,	it the time in my opir	, date and p nion, death	place, ar occurred	nd due to the d at the time,	cause(s) and	and manner place, and d	as stati	ed. ne cause(s)	
	vith To 1		29b. Signature and title of certifier	2 /			License r					signed (Mo			
			1 Robert	me	M		1)00	0093	317		3	131	106		
5)	02		30. Name and address of person who com				1:-	-11 -	C 25	1		/	11	2 -	
í	Stat	e	Kobent F 346 31. Date filed (Month, Day, Year)	32. Fagistrar's). 233 Signature	1 5	NUA.	of 3) [MAC	1261	en, U	14	2220	2
	Registra		MAR 0 7 200	400		Court 1	97								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Katherine 6:35 P M February 28, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Fort Washington

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

July 21,1929 Fort Washington Hospital Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 21 F 579-48-2948 Director 76 South Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1 Yes 21 No Directo Maryland Prince Georges Accokeek 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15496 Old Marshall Hall Road 20607 USA Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2/XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ğ 1 ☐ Yes 2 🗓 No Specify: SpecifyWhite 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental J. Rowan Kate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau <u>once</u>. Howard Vess - Husband 15496 Old Marshall Hall Rd., Accokeek, MD 20607 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory March 2, 2006Edgewater, MD 21. Signature of Funeral Service Licensee George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): .O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death signed by the a d be detached for 5 Other (specify) 9 Unknown 9 Unknown Pag II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 X Yes 3 Probably 4 Unknown 2 🗆 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s certificate 1 ☐ Yes 2 🛴 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number deted cause of death (Item 23a) (Type, Print) 30. Name and address of person who com Louis V. Kaufman M.D. 12070 Old Line Centre #207, Waldorf, MD 20602 31. Date filed (Month, Day, Year) State MAR 0 2 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** FEBRUARY 15, 2006 9:15P M MARCIA LAUREL WAPLES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES MALCOLM GROW MEDICAL CENTER CAMP SPRINGS If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2XXF Months Days Hours 61 Yrs. 1944 149 32 6978 JULY 08, PENNŚYLVANIA Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show Examinar must be notified at XX Yes 2 □ No Director PRINCE GEORGES SUITLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 or 3007 SUNSET LANE 20746 238 UNITED STATES death Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 22No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours efter 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 Yes XX No If Yes, Give Year or Dates: Specify Specify: BLACK δ 3 Widowed XX Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 4 YRS. ENVIRONMENTALIST FEDERAL GOVERNMENT other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be n and Mental LAURENCE HOWARD WAPLES, SR. EUNICE MOORE 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heelth a important: if item 27 is any injury or other tra COLLIN EDWARDS / SON 3007 SUNSET LANE SUITLAND, MD 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial XX Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 2/24/2006 ALEXANDRIA, VA 21. Signature of Funeral Service Lice 22. MARSHALL S FAUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 Approximate Interval Between Onset and Death nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate dause (Final **Physician** CORONARY ARTERY DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed HYPERTENSTION physician and s the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) 4 Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes XX No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy med? XXNo certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpatient | Inpa Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ XXYes 2□ No this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Manner of Death 28d. Describe how injury occurred Certification: After XXNatural 5 Pending investigation 2 🗌 No Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a e Funerai I 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I the 29d. Date signed (Month, Day, Year) title of certifier 29c. License number 29b. Signature an FEBRUARY 22, 2006 D0059658 10 30. Name and a lore's of person who completed cause of death (Item 23a) (Type, Print) OLD BRANCH AVENUE KAISER PERMANENTE CLINTON, MD JOHN LEE, M.D.

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

MAR 0 3 2006

Box 68760.

P.0.

Records,

Division of Vital

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day KELCE WIREMAN JR. MARCH 14 2006 2:51a /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Chester River Hospital Center Chestertown Kent 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1⊠M 2□F Director 232-16-2962 90 1915 West Virginia Usual Residence of Decedent the Maryland 10b. County 10a, State 10c. City, Town or Location show 10d. Inside City Limits "natural", or Itams 23a or 28a-f shov dicul Examiner must be notified at Director MD 1 ☐ Yes 2 ☑ No Kent Massey 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Health and Mental Hygiene. Int: If itam 27 Is marked othar than "natural", or Itams 23a or : 34097 Lees Chapel Rd. 21650 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No 1942 If Yes, Give Year or Dates: -1945 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 ð 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed traumatic avant, I've Medicul 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Meat Processing Elementary/Secondary (0-12) College (1-4or 5+) Machine Repairman 9 Plant 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Kelce Wireman, 2 Alma Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Wireman (wife) P.O. Box 63 Massey, MD. 21650 itam 2 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ŏ 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Holly Hill Memorial 3/17/06 Middle River, MD. `4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Galena Funeral Home of Stephen L. M00510118 West Cross St. Galena, MD. 216 21635
Approximate
Interval Between
Onset and Death 23a Part. Enter the disease, or complications that caused the death. Do not enter the made of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause An each line. Immediate Cause (Final disease or condition resulting in death) SPIRATION **Physician** HUMONIA /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attanding Physician: The law requires that the death certificate be executed as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760. the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No Completed 3 Probably 4 □Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of Injury 28d. Describe how injury occurred After 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No Diractor: the 6 Could not be determined 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours a Certifying Physician: To the best of my nowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 7 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0060301 ress of person who completed cause of death (Item 23a) (Type, Print) 122 Speer Rd. Chestertown, MD. 21620 Michael E. Peimer, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 2006 Registrar

				Plea	se Type or											ble.		
				For Stata Registrar	State	of Maryla	and / I		rtment <i>ificate</i>			ina ivi		Reg. No	A 3	£"	184	5.6
_	(C)	Physici /Medi		Decedent's Name (First, Middle Pearl	A. Webste	er							2. Date of De Month	Da		Year 2006		of Death
		Examir		4a. Facility Name (If not institution Doctors Communication)					4b. City, I Lanl		Location o	f Death	,			of Death Ce Ge	orge	
		Funeral Director		5. Social Security Number 579–46–5937	6. Sex 1 ☐ M 2 🖰 F	7. Age (In y	rs. last bii	rthday) Yrs.	If Under	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da Oct. 1	ay, Year,	939			on , DC
		anyland •how	_	Usual Residence of Decedent 10a. State 10b. County Maryland Prince	ce George	10c.	City, Tow											City Limits
		death with the Maryland ms 23s or 28a-f show Haars te Hattling at	Director	10e. Street and Number 3001 Viceroy					10f. Zip		0747					What Cou Stat		
	36	rs after death ' ', or items 23	by Funerai	11. Marital Status 1 □ Never Married 2 □ Mar 3本 Widowed 4 □ Divorce	12. Was De Armed F nied 1Yes	2X No Sive	n U.S.	If	as Decede Yes, speci	ent of His ify Cuban	panic Orig	gin? (Spe i, Puerto f	cify Yes or No Rican, etc.)	0-	Blac	e - Americk, White,		,
Agnes	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene important: if item 27 is marked other then "natural", or items 23s or 28s-1 show ampirity or other traumatic event, the Madical Exampler must be notified at once.	Completed I	15. Deceder	nt's Education st grade completed			Decede (Give k life. D	ent's Usual ind of won O NOT use	l Occupat k done du e retired)	tion uring most	t of workii	ng			usiness/lr nment		
Pearl	land 2	uld be filed fental Hygi rked other tic event, I	To Be C	17. Father's Name (First, Middle, Hugh E. King	Last)						18. Mothe		(First, Middle sie Ba			ne)		
	Mary	nd 2 shou lith and N 27 ie mei r fraumai		19a. Informant's Name/Relation: Gilbert Webst									ale, M		or Town.		Code)	
Webster,	nore,	ages 1 ar ant of Hea at: If item:		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (3)		n State i			ition (Namatory or of				4, 200				own, State	
X	Baltir	permit. F Departmi importar eny injur		21. Signature of Funeral Service	1	M 011	084	22.	Name and	d Address		y Po		eral Ibor	o Hor o MD	les Lke 20	747	
4	15 mm	Physician		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final		caused the deach line.						cardiac o	r respiratory a	arrest,			Approxim Interval I Onset ar	nate Between nd Death
	1	/Medical Examiner		disease or condition resulting in death)	Due to	o (or as a con: iabetes	sequence	of):		DISE	156				·			
		uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	o (or as a cons	sequence	of):		seas	e							
	8760,	ate be execute hysician and the burial-tran		resulting in death) Last	Due to	o (or as a cons												
	O. Box 68760,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live	outcome of pre birth 2 F gnant at time on thown	etal death		Ectopic pre Other (spe							ite of deliv	ery Day	Year
	S, P	res that igned b	by	Part II. Other significant condit			resulting	in the un	derlying ca	au <i>s</i> e give	n in Part I.			tobacco Yes 2		tribute to t	he cause	of death?
	ecorc	The law requi ate has been s page 2 should	Completed	End Stage Rena Hypertension	ir bisease	<u> </u>							24a. Was	s an	/24b.	Were aut	opsy findin	igs available of cause of
	Vital F	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	⊇ □ ER/O	utaatiant	3 DO	Cthe			1 ☐ Yes (Check only me 5 ☐ Res	2 2 N oлe)	0	1 🗌 Yes		
	Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	ation: To	27. Manner of Death 1 ☑Natural 5 ☐ Pendi	28a. Dat	e of Injury onth, Day Year		Time of Injury		8c. Injury Work		1	28d. Describe				'97	
	Divis	s after des s after des al Directo	Certification:	3 Suicide 6 Could deten	minod 289. Plai	ce of Injury - A Iding, etc. (Sp	At home, f	arm, stre	et, factory	r, office		1	28f. Location City or To			ber or Rur	al Route N	lumber,
		he Hospii in 24 hour he Funera pletely fille	Medical (ng Physician: To the I Examiner: On the and ma				estigation,	, in my op	inion, dea			, date ar	nd place,	and due t	to the caus	
		To t Withi To tl	Σ	29b. Signature and title of certifit Jaleh	Dac	Sm.	0		,		32			0	2-2	8-0	Day, Yea	7)
C	R	(8)		30. Name and address of person	who completed ca	use of death (Item 23a)	(Type, F	Print)	JAL	LEH	- 1< M	- DA	EE	5 M	·D .		

State Registrar 31. Date filed (Month, Day, Year)

MAR 0 2 2006

1's Rd. Suite # 418

			1 - For State of Maryland / De State of Maryland / De State		rtment of H		ind Me		jiene leg. No.	106	08457
	. · · ·		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day	Year	3. Time of Death
Ning.	Physicia /Medic		Elijah Wheeler					Februar	y 26	2006	12:25Pm M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or					ounty of Death	
			Fort Washington Hospital 5 Social Security Number 6. Sex 7. Age (In yrs. last birth)	_	Fort Was	hingt If Under 2		8. Date of Birth		ince Ge	orge place (State or Foreign
	Funeral			rs.	Months Days	Hours	Min	Month, Day	Year)	Cou	ntry)
	Director		Usual Residence of Decedent					,,,	1713	GCOI	514
	yiand you		10a. State 10b. County 10c. City, Town of	or Loca	ation						10d. Inside City Limits
	Mar 9-f st	iç	Maryland Prince George Temple	e H	lills						1 ☑ Yes 2 ☐ No
	or 28	Oire	10e. Street and Number		10f. Zip Code				10g. Citize	n of What Cou	ntry?
	ath w	Funeral Directo	6924 Allentown Rd.			748				ted Sta	
	er de items	nue		13. W	as Decedent of H Yes, specify Cuba	ispanic Orig in, Mexican	gin? (Spec , Puerto R	cify Yes or No- lican, etc.)	14	. Race - Ameri Black, White	
36	irs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 3 ☒ Widowed 4 ☐ Divorced Year or Dates:	1(☐ Yes 2☑ No	Specify:			S	pecify: B1	ack
Š	within 72 hours after death with the Maryland ene. Itan "naturel", or items 23a or 28e-f show The Medical Evantrar must be notified at	ted	15. Decedent's Education 16a. D	Decede	ent's Usual Occup	ation	t of workin		16b. Kind	of Business/Ir	ndustry
215	hin 7 e. an "n Med	pie	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. Do	ind of work done of NOT use retired	d)	OF WORKIN	9			
2	ed wil	Completed		int	enance E	ngine	er	(C) 1 1 1 1 1 1		Privat	e
<u>n</u>	ould be filled a Mental Hygie larked other l	Be	17. Father's Name (<i>First, Middle, Last</i>) Ezekiel Wheeler					(First, Middle,		imame)	
<u>Ş</u>	2 should be filed within 72 hours after death with the Marylan and Menth Hyglene is and Menth Hyglene is marked to the than "naturet, or items 23a or 28e-1 show is marked out it a Medical Examinar must be notified at equation.	2		Mailing	Address (Street				-	Tourn State Zi	o Code)
Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other treumatic evones.				Allentow						748
ē,	Heal Heal Hem		20a. Method of Disposition 20b. Place of Disposition		ition (Name of atory or other place			ate nii		tion - City or T	
altimore,	Page: ent of nt: if i		1 Alburiai 2 I Cremation 3 I Removal from State		emorial (arch 6	, 2006	Suit	land, l	MD.
a	mit. partm ports ports y inju		21. Signature of Funeral Service Licensee		Name and Addres		y Pot	e Fune	ral F	lomes	
œ.	B B E B		· Cwa & //ellel				For	88 Marl	boro le, M	D. 20	747
2			23a. Part1. Enter the disease, of complications that caused the death. Do no shock, or heart failure. List only one cause on each line.		-						Approximate Interval Between Onset and Death
pie.	Paysician		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	. J.	escula.	- (er /	cost			Chisot and Boath
ı	/Médical Examiner		resulting in death) Due to (or as a consequence of	f):		٠,	11	/	_		
П		_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of	D /	in test.	n 4/	140	san arr	hai	ge :	
Т	ited Insit	mine	cause. Enter Underlying Cause (Disease or injury								
<u>,</u>	execu n and ial-tra	Examiner	that initiated events c Due to (or as a consequence of	f):							
760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rate director, page 2 should be detached for use as the burial-transit	icai	d								
99	ng ph		IF FEMALE:								
õ	ath ce Itendi	an/I	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death		Ectopic pregnancy	,			23	d. Date of deliver Month	rery Day Year
P.O. Box	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Med	1 Yes 2 No 9 Unknown	5 🗀 '	Other (specify)						
٥.	that the sed by detac		Part II. Other significant conditions contributing to death but not resulting in t	the unc	derlying cause giv	en in Part I.		23e. Did to	bacco use	contribute to	the cause of death?
Records,	uires sign ld be	d by	Demenhar					1 □ Y	es 2□	No 3□Pro	bably 4 Dunknown
COL	w req	iete	Feeding dys fract	6.00				24a. Was	an	24b. Were aut	opsy findings available ompletion of cause of
Be	Physician: The lav this certificate has al director, page 2	Completed)			-		autop perfor 1 Yes	med?	prior to or death? 1 ☐ Yes	
tal	an: rtifica tor, p	Be C	25. Was case referred to medical			26. Place	of Death	(Check only o			
>	nysici nis ce direc	TO E	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp	patient		4 🗆 Nu	rsing Hom	ne 5 🗆 Resid	lence 6 [Other (Spec	fy)
0	ng Pl		27. Manner of Death 28a. Date of Injury 28b. Tir	ime of ijury	28c. Injur Wor			8d. Describe h	ow injury	occurred	
Sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm	T etro		Yes 2□		8f Location /9	Street and	Number or Rui	al Route Number,
Division of Vital	or All after of Direction by	Certification:	4 Homicide determined building, etc. (Specify)	III, SII e	et, lactory, office			City or Tow	m, State)	11001 OF 1107	arrobio mambor,
_	To the Hospital or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer		29a. Certifier 1 Certifying Physicien: To the best of my knowledge,								
	he Ho in 24 I he Fu pletely	edical	(Check only one) 2 Medicel Examiner: On the basis of examination and and manner stated.	Vor inve	estigation, in my o	pinion, dea	th occurre				
	vithi To th	Σ	29b. Signature and title of certifier		29c. Licens	e number	0			signed (Month	•
2	$\vec{\Omega}$		· Land			121	7 2			120/	<i>- - - - - - - - - -</i>
	6		30. Name and address of person who completed cause of death (Item 23a) (TEdgar Potter	1_	17	Was	6,-	- ston	N	1d.	
	Sta Registr		31. Date filed (Month, Day, Year) A2. Registrar's Signature MAR 0 2 2006	200	E)			<i>U</i> ——			

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day MARY VIRGINIA YENCHICK February 28, 2006 1:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8510 Carrolton Parkway Prince George's New Carrollton 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2፟MF Yrs. 578-58-0580 Director 1, 1929 Pennsylvania Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Localion 10d. Inside City Limits or 28a-f show the Mudical Examiner must be notified at 1 X Yes 2 □ No Maryland Prince George's New Carrollton Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 8510 Carrolton Parkway 20784 U.S.A. death ! Funeral 12. Was Decedenl Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian filed within 72 hours after 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married P. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedenl's Education 16b. Kind of Business/Industry (Specify only highest grade completed) th and Mental Hygiene.

7 Is marked other than traumatic avent, the Market Elementary/Secondary (0-12) College (1-4or 5+) Office Management Lawfirm permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any liquy or other traumatic avent RRB. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andrew Yenchick Mary Guza 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kristine E. Wilhelm - Friend 8510 Carrolton Parkway, New Carrollton, MD 20784
Date of Disposition (Name of 2002) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cemetery 3/3/2006 Silver Spring, Maryland 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service 100000 4739 Baltimore Ave., Hyattsville, MD 20781 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer of the Lung **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any loading to in reclass cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disa to (ur as a consequence of) Examiner physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a Ö 9 Unknown 9 Unknown ٥. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ cate has been signated by page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes Be funeral director 25. Was case referred to medical 26. Place of Death / Check only one Hospital: 1 | Inpalient Other: 4 Nursing Home 5 🕅 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 X No 2 ER/Outpatient 3□ DOA this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury al Work? After t 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 Tyes 2 No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ö To the Hospitel c within 24 hours at To the Funerel E completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D23743 3/2/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7525 Greenway Center Drive, Greenbelt, Maryland 20770 Martin Weltz, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 0 3 200\$

			1 - For State Registrar	State of Ma	ryland		artmen tificate				_	giene Reg. No	HILL	084	59
	Physic	an	Decedent's Name (First, Middle, Last)	7.1					***		2. Date of De Month Mar.		Yo o c Yea	3. Time of	Death
1	/Medi Examir		Guillermo 4a. Facility Name (If not institution, give s Shady Grove Adv		ауа			Town, or Ckvi	Location o	of Death	Mar.	4c.	County of De Iontgo		M
	Funeral Director		5. Social Security Number 2.15 - 9.6 - 5.376 1D Usual Residence of Decedent		(In yrs. las	t birthday) Yrs.	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Bird (Month, Da Feb. 1	y, Year)		Birthplace (State of Country) El Salv	
	ne Maryland Ba-f show	ctor	10a. State 10b. County MD Montgon	nery		Town or Lo							10d. Inside City Limits 1 Tyes 2 No		
	3a or 2	Dire	10e. Street and Number 4802 Flanders A	venue			10f. Zip	code 2089	5			_	izen of What Salva	,	
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. ie marked other then "netural", or items 23s or 28s-1 show summatic event, Its Medical Examinat must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		1	X Yes 2	2⊡ No		_	cify Yes or No Rican, etc.)		14. Race - Ar Black, WI Specify:	merican Indian, nite, etc.	
or Vital Records, P.O. Box 68760, Mar. Baltimore, Mar.	d within 72 ho giane. er then "netu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of works) life. DO NOT use retired) Carpenter								ng		ss/Industry action		
yland	ould be file Mental Hy tarked oth	To Be (17. Father's Name (First, Middle, Last) Antonio Zelaya						Me	erce	(First, Middle, des Ze	elay	'a		
2	and 2 sh ealth and n 27 ie m		19a. Informant's Name/Relationship (Ty) Nestor Sandoval		on	19b. Mailin	g Address 28 Li	(Street a	nd Numbe ty H	or or Rura leigi	hts La	er, City o	r Town, State Germa	. Zip Co@087 ntown, N	7 4 1d
imore,	Pages 1 nent of He ent: if iter ury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation / 5 ☐ Other (Specify)	emoval from State	1	e of Dispos netery, crem			9)	3/10	/06	20c. Lo Si E1	ocation City of an Mic Salva	or Town State guel, dor	
Balt	permit. Departr Importe any Inju		21. Signatura of Funeral Service Userise	L							FUNE	RAL	SERV	ICE, P.A ing, Md2	
8/60,	Physician and // // // // // // // // // // // // //	dical Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequer	nce of).	Co	707	rang	di	seas e			Interval Betwonset and D	
. Box	the death certific y the attending p iched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \[Yes \ 2 \] No 9 \[Unknown \] 23c. If yes, outcome of pregnancy 1 \[Live birth 2 \] Fetal death 3 \[Ectopic pregnancy \] 4 \[Pregnant at time of death 9 \] Unknown 5 \[Other (specify) \]										23d. Date of d Month	,	9 8 .r
_	w requires that the de been signed by the a should be detached f	ρ										bacco use contribute to the cause of death? es 2⊠No 3□Probably 4□Unknown			
ľ	The law ete hes b page 2 si	e Completed	25. Was case referred to medical	7.0							1 ☐ Yes	sy med? 20 No	24b. Were a prior to death?		vailable use of
<u> </u>	Physician: this certific ral director,	To Be	examiner?	ospital:	2 ☐ ER	/Outpatient	3 DO	0			(Check only or ie 5 ☐ Resid		S DOther (So	ecity)	-
Ç	a free		27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28	b. Time of Injury		c. Injury Work		2	8d. Describe h			<i>55.</i> 17)	
DIVISION	To the Hospits! or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the to	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	(Specify)			_			City or Tow	m, State,)	Rural Route Numb	Θ/,
	• Hosp 24 hou • Fune letely fil	edlcal	29a. Certifier (Check only one) **Certifying Phys 2 Medical Examin	cian: To the best of er: On the basis of e and manner state	xamination	dge, death and/or inve	occurred a estigation,	t the time in my opi	e, date and inion, deat	d place, a h occurre	nd due to the o d at the time, o	ause(s) date and	and manner a place, and di	as stated. ue to the cause(s)	
•	To the comp	Me	29b. Signature and title of certifier Acicia. A	listy	MD		29c.	License	number	E				nth, Day, Year)	
			30. Name and address of person who cor Alicia T. Mistr		ith (Item 23	Ba) (Type, P	Print)	ter	Or,	ve				20856	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 6 21	32. Registrar			ole .								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Day 19. March **Physician** Fred Allen 2006 15:30pm /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis Nursing Home Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 09 05 Birthplace (State or Foreign Country)
 NC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1**∑**M 2□ F 70 Director 217-30-4828 Usual Residence of Decedent the Maryland 10h County 10c. City, Town or Location 10d. fnside City Limits 10a State 28a-f ehow interns 23s or 28s-f ehover the continued at 1 Tyes 2 No Randallstown Baltimore Director MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21133 9109 Liberty Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married TvYes 2 ☐ No Yes, Give ō 1 ☐ Yes 2 No Specify: traumatic event, the Musical Exp. Specify: 2 Black 3 Widowed 4 Divorced Year or Dates: natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) John Hopkins Hosp. Cook 12th grade na is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental Virginia Little Leroy Allen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4132 Carroll Ave, Rocky Mount, NC 27804 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If Itam 27 is n any injury or other traun once. 4132 Carroll Ave, Rocky Frederick Allen-son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ▼ Burial 2 □ Cremation 3 □ Removal from State Baltimore, Baltimore National 3/23/06 Md Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service Licensee 22. Name and Address of Facility Baltimore, Md. 4300 Wabash Ave. March F.H. West 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** -2 HEIMER DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto for seig nonecoganna offi Examiner certificate be executed use as the burial-transit Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day į Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MELLITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 TNO After this certification, I 25. Was case referred to medical Be 26. Place of Death | Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Attending 1 Natural 5 Pending To the Hospital or Attendia within 24 hours efter death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No death investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) D0059177

State Registrar

Baltimore, Maryland 21215-0036

Box 68760.

P.O. I

Division of Vital Records,

DHMH 17 Rev 1/2001

ORIGINAL

AVENUE

BALTIMORE NO 21215

LIRERTY HEILINGS

32. Registrir's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2600

2005

UMA

31. Date filed (Month, Day Year) WAR 2

			1 - For State Registrar	State of Maryland /		artment ortificate				Reg. No	anr -	08462
	Physici	an	1. Decedent's Name (First, Middle, Last) Kenneth L. A1						2. Date of D Month March		^{ту} 2006 ^{Үөаг}	3. Time of Death 3:57 AM
	/Medic Examin		4a. Facility Name (If not institution, give s Southern Maryla	street and number)		C	1int		ath		County of Death	e George's
	Funeral Director		5. Social Security Number 6. Sex 579 38 3356	7. Age (In yrs. last b	Yrs.	If Under 1 Months E		If Under 24 H Hours Mi		ay, Year)		place (State or Foreign htry) nington DC
	Maryland a-f show	tor	10a. State 10b. County Maryland Prince	George's 10c. City, Tov							1	0d. Inside City Limits 1 ☐ Yes 2XXNo
	th with the 23a or 28 unt be not	ai Director	10e. Street and Number 6104 Buckler R	oad		10f. Zip Ci	ode 2073	55			itizen of What Cour ited Stat	•
036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or flame 23a or 28a-f show avent, the Madical Exarting must be notified at	by Funerai	11. Marital Status 1 Never Married XXMarried 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1√74'es 2 □ No 1952 If Yes, Give Year or Dates:	ĺ	Was Deceder if Yes, specify 1 ☐ Yes 2 ☐		panic Origin? Mexican, Pui Specify:	(Specify Yes or Nerto Rican, etc.)	0-	14. Race - Americ Black, White, Specify: White	etc.
9500-61212	l within 72 ho iene. r than "natur the Wed cal	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12 Years	College (1-4or 5+)	(Give	dent's Usual (kind of work DO NOT use I actui	Occupation done dur retired)	on ring most of w	vorking		and of Business/Ind	
Maryland	d tal	To Be C	17. Father's Name (First, Middle, Last) George Allen				- 5		lame (First, Middle a Fisher		n Sumame)	
	and 2 sho salth and I n 27 is mu		19a. Informant's Name/Relationship (Ty, Barbara Allen (Wi	fe)	61	04 Buc	k1er	Road,	Clinton	, MD		,
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 ie marke any injury or othar traumatic once.		20a. Method of Disposition 1XXBurial 2 Cremation 3 R 4 Donation 5 Other (Specify)		igto	sition (Name natory or othe n Nati	ona1	Cemet	ery	Ar	ocation - City or To 1 ington,	Virginia
Balt	permit. Departr Importa		21. Signature of Funeral Service License	al/20153	22	Name and Alexan	Address dria	of Facility L	ee Funer Road, C	al H lint	ome,Inc 6	563301d 0735
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do le cause on each line.	tu	er the mode of	of dying,	such as card	iac or respiratory a	arrest,		Approximate Interval Between Onset and Death
8/60,	certificate be executed ading physician and use as the burial-transit	dical Examiner	Se pontially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence Due to (or as a consequence								
O. Box 6	death e atter	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown		Ectopic preg Other (spec					23d. Date of delive Month	ery Day Year
rds, P	law requires that the de as been signed by the a 2 should be detached f		Part II. Other significant conditions cor	ntributing to death but not resulting	in the u	nderlying cau	se given	in Part I.	1	tobacco Yes 2	use contribute to the	ne cause of death?
I Kecords,	The ate h page	Completed by	arterovenous	udur pulmo	na	ry o	tis	lase	24a. Wa: auto peri 1 □ Yes	opsy ormed?	prior to con death?	psy findings available mpletion of cause of 2. No
or Vital	Physician: The law this certificate has t al director, page 2 s	To Be (25. Was case referred to medical examiner? 1 Yes 2 140	lospital: 1 1 Inpatient 2 ER/O	utpatier	it 3□ DOA	Other:		eath <i>(Check only</i> Home 5 Res		6 ☐Other (Specifi	y)
DIVISION 0	ding P. h. After t	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		Time of	M 28c	: Injury a Work? 1 ☐ Ye	s 2 No	28d. Describe	how inju	iry occurred	
N N	To the Hospitel or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.		4 Homicide determined	28e. Place of Injury - At home, f building, etc. (Specify)					City or To	wn, State		
	the Hosp hin 24 hou the Fune upletely fi	Medicai	(Check only 2 Medical Examilione)	sician: To the best of my knowledg ner: On the basis of examination a and manner stated.	ge, deat nd/or in	vestigation, in	n my opin	nion, death oc	ice, and due to the courred at the time	, date an	d place, and due to	the cause(s)
)	Twitwit		29b. Signature and title of confidence	terson w	×.	1	DIC	163	3	3	ate signed (Month,	uay, teat)
	1071	10	30. Name and address of person who co	mpleted cause of death (Item 23a) MD. 7501 32. Signitrar's Signature	Type,	ralls?	2017	#2011	A Clint	on,	Md. 2	.0735
	Sta	re		ine k	1	ach s						

			1 - For Stete Registrar	State	of Marylan	-	artment of H rtificate of I	leaith and M Death		ene 2.006	081.63			
			Decedent's Name (First, Middle	e, Last)			timodito or i	504.77	2. Date of Death	. No. C. C. C.	3. Time of Death			
	Physicia			Sarah Har	nah Arn	old.			Month March 17	Day Year	7:08 p M			
	/Medic Examin	7	4a. Facility Name (If not institutio			OTG	4b. City, Town, or	r Location of Death	1101 011 17	4c. County of Death				
	LXumm	Ξ'	0.	entinuum Cor	o at Culcasi	illo		Syk	esville	0	arroll			
-	Funeral		Social Security Number	ontinuum Care 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		andin nplace (State or Foreign untry)			
	Director		216.66.4380	1 □ M 2 X F	8	4 Yrs.	Months Days	Hours Min.	(Month, Day, Y	ear) Col	intry)			
	D.		Usual Residence of Decedent						April 26, 19	921	Maryland			
	thow	_	10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 No			
	Ba-f s	cto	Maryland											
	or 2	Director	10e. Street and Number				10f. Zip Code		10g	. Citizen of What Co	untry?			
	ath v	ä	7577 Braemar Cou				U.S.A.							
	er de	Funerai	11. Marital Status	Armed F			Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White				
2	rs aft	by F	1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced	If Yes G	No live:		1□Yes 2♥No	Specify:		Specify:	White			
3	tura is E			it's Education		16a Dece	dent's Usual Occup	ation	16	b. Kind of Business/l				
2	in 72	Completed	(Specify only highe	st grade completed		(Give	kind of work done of DO NOT use retired	du <i>rina most of worki</i>	ing		•			
7	iene r tha	E	Elementary/Secondary (0-12)	College	(1-4or 5+)		hon	nemaker		at r	at home			
2	illec Hyg other ent,	Be C	17. Father's Name (First, Middle,	Last)		1			(First, Middle, Ma	iden Sumame)				
ō	should be filed within 72 hours after death with the Maryland nod Mental Hygiene. Indexted other than "natural", or items 23a or 28a-f show unatic event, The Medical Evan Fermusi be notified at	To B	Herh	ert Jerry Mad	7 0				Many	Etta White				
<u></u>	12 should be filed within h and Mental Hygiene. 7 is marked other than iraumatic event, I'm Me	-	19a. informant's Name/Relations		yc	19b. Mailir	ng Address (Street	and Number or Rura		City or Town, State, Z	ip Code)			
Ě	and 2 salth a n 27 is		Ms. Deborah Ann	Colo Cr	andchild	7	577 Braemar	Court Sykes	ville Maryland	1 21784				
בָּ ת	item item		20a. Method of Disposition		20b. P	Place of Dispo	sition (Name of natory or other place			c. Location - City or	Town, State			
=	Pages nent of I ant: If its		1 Burial 2 □ Cremation 1 Donation 5 □ Other (5		n State			03/	22/2006	Baltimore	Manyland			
<u>=</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Intepartment of Health and Mental Hygiene. Importment: If the Z7 is marked other than "natural; or Items 23a or 28a-1 show any injury or other traumatic event, the Modital Examinating must be notified at once.		21. Signature of Funeral Service	Licensee	f 10	22	Dudon Park Name and Addres	ss of Facility	LL/LOGO 1	Baltimore	Waryland			
۵	89 = 88		UNUMLIX	Phetou	at Men	293	Slack F	uneral Home	, P.A.					
			23a. Part1. Sofer the disease, o shock, or heart failure. List	complications that	caused the deat	h. Do not ent	er the mode of dyin	ig Columbia i	Crike Fallicott C	ity, MD 21043	Approximate Interval Between			
Е	Physician		Immediate Cause (Final disease or condition Oronary Arters //reas											
	/Medical		resulting in death)	Due to	(or as a conseq		12090	,,,,,			Person			
	Examiner		Sequentially list conditions,		(kus)									
	pe is	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	o (or as a conseq	uence of):								
	and -tran	каш	that initiated events resulting in death) Last	C	o (or as a conseq	Hence of):								
0000	reate be executed physician and s the burial-transit	a E	-											
0		dical		d										
۲ ۲	certif ading se as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome of pregna	incy	-			23d. Date of deli-	verv			
0	atter affor u	ciar	in the past 12 months?	1 ☐ Live 4 ☐ Preg		Month	Day Year							
į	the c yy the achec	Physician/M	9 Unknown	9□ Unk										
ř	Physicien: The law requires that the death certific this certificate has been signed by the atlending praid director, page 2 should be detached for use as	by P	Part II. Other significant conditi	ons contributing to	23e. Did tobacco use contribute to the cause of death?									
, COLON	w require been sig should b								1 ☐ Yes	2 No 3 □ Pro	bably 4 Unknown			
2	s bee	Completed							24a. Was an	24b. Were aut	topsy findings available ompletion of cause of			
ב	The te ha	Eo							autopsy performe 1 Yes 2	death? No 1 ☐ Yes				
g	en: rtifica tor, p	0	25. Was case referred to medica	t				26. Place of Death	(Check only one)	LNO 12165	20110			
>	ysici is cei direc	To B	examiner?	Hospital: 1	Inpatient 2	ER/Outpatien	t 3 DOA Oth	er: 4 Vursing Ho	me 5 Residence	ce 6 Other (Spec	ify)			
5	ig Ph		27. Manner of Death 1 Natural 5 □ Pendir	28a. Date (Mo	of Injury nth, Day Year)	28b. Time of Injury	28c. Injun Worl	y at k?	28d. Describe how	injury occurred				
	ath. er: Af	atic	2 Accident investi	gation	,,	,,		Yes 2 □No						
<u>"</u>	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 280. Place	e of Injury - At he	ome, farm, str	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Rus State)	ral Route Number,			
ב	ital o irs aff ral Di led ir		· · · · · · · · · · · · · · · · · · ·											
	Hosp 14 hou Fune Fely fil	edical	(Check only 2 Medical	Examiner: On the	basis of examina	wledge, death tion and/or in	occurred at the tin vestigation, in my o	ne, date and place, a pinion, death occurr	and due to the caus ed at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)			
25. Was case referred to medical examiner? 26. Place of Death (Check only placed of Line) 25. Was case referred to medical examiner? 27. Manner of Death 1 1 1 1 1 1 1 1 1										. Date signed (Month	, Day, Year)			
	E ME S		1 7.8	1/1/1-	1 110		00	10817	, ,	12010				
			30. Name and address of person	who completed car	use of death (Item	1 23a) (Type	Print)	12012/		, / 20/00	0			
	10		Wilber	Luo	295	Sto	ner Aus	St 20	2 West	mine tes 10	711501			
	Sta	te	31. Date filed (Month, Day, Year,	32	legistrar's Signa	iture /	adles		, , , , , , , , , , , , , , , , , , ,	2/5"	MD 7115-7			
	Registr	ar	MAR 2	2006	Man 1	U M	000							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** SAMUEL AURIT /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore + DUMMINE IMAI N/A 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. ial Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min 1 M 2 □ F 164-18-1457 Director 05/02/1921 PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show or other treumatic event, the Modical Examiner total be notified at 1 ☐Yes 2 ☐ No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 2807 QUARRY HEIGHTS WAY 21209 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 MYes 2 NoARMY If Wes, Give ARMY Year or Dates: 1 Never Married 2 Marned 1 Yes 2 No WHITE þ 3 ♥ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important if item 27 is marked other than any injury or other treismetin. College (1-4or 5+) Elementary/Secondary (0-12) MILITARY OFFICER U.S. ARMY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) MORRIS AURIT JENNIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELLEN PINSKY / DAUGHTER 2807 QUARRY HEIGHTS WAY - BALTIMORE, MD 21209 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Donation 5 Other (Specify) ROOSEVELT MEMORIAL PARKO3/19/2006 TREVOSE, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examine burial-transit and Division of Vital Records, P.O. Box 68760. attending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacce-use contribute to the cause of death? Ď 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 No 1 ☐ Yes 2 ☐ No 1□ Yes i or Attanding Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 - npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o. within 24 hours aft To the Funerel Di Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical (Check only one) 29b. Signature ed cause of death (Item 23a) (Type, Print) 10 30. Nar

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 2 1 2006

egistrar's Signature

			1 - For State Registrar	State of M	arylar		artment of H		d Mental Hy	giene	005	08466	
ı	.		Decedent's Name (First, Middle,	Last)				· · · · · ·	2. Date of Dea		Year	3. Time of Death	
	Physici /Medio		William		E.		Bean		mard	18	2004	1150 1	
	Examin	er	4a. Facility Name (If not institution,	10/25			4b. City, Town, o		eath	4c. C	County of Death		
	Funeral		Union Mem. Hos 5. Social Security Number		ge (In yrs.	last birthday)	If Under 1 Year	imore If Under 24 F	frs. 8. Date of Birt	h	NA 9. Birth	place (State or Foreign	
	Director		213-22-2497	1 X M 2□F	80	Yrs.	Months Days	Hours M	lin. (Month, Da) 8-11-	, Year)	Cou	Md.	
	pud *		Usual Residence of Decedent 10a. State 10b. County		10c Ci	ty, Town or Lo	ncation					10d. Inside City Limits	
	Maryla	ō	Md. NA			*	timore					1 XYes 2 No	
	death with the Maryland rms 23s or 28s-f show finust be notified at	Director	10e. Street and Number 1917 Oak Hill Avenue 21218							10g. Citize	ntry?		
		Funeral	11. Marital Status 1 □ Never Married 27. Married	12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)							USA 14. Race - American Indian, Black, White, etc.		
	ural', c	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 21⁄2 No	Specify:			Specify: Bl	ack ———————	
ה	filed within 72 hours after Hygiene. hther than "natural", or lite int, the Madical Examine	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16 (Give kind of work done during most of working life. DO NOT use retired)							16b. Kind	b. Kind of Business/Industry		
7	e filed within al Hygiene. I other than " vent, the Met	шо	Elementary/Secondary (0-12)	College (1-4or	5+)		uck Drive	•		Ma	son Dix	on	
מום,	be filed tal Hyg d othe	Bec	17. Father's Name (First, Middle, La	ist)				18. Mother's h	Name (First, Middle,	Maiden S	Sumame)		
Z Z	2 should be and Mental is marked o	ဥ	William	Α.			an	Mary			Parker		
Z Z	d 2 sh th and 27 is n traun		19a. Informant's Name/Relationship Dorothy Bean	Wife					Rural Route Number, Baltimor				
ย์	s 1 and if Health item 27 other to		20a. Method of Disposition			Place of Dispo	sition (Name of matory or other place		Date		ation - City or To	218 own, State	
	Pages nent of ant: If it ury or o		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe				dge Cem.		24/06	Bal	timore	MD	
Z Z	permit. Pages 1 and Department of Healinportant: if item 2 any injury or other ance.		21. Signature Funeral Service Li	ensee /			2. Name and Addre				ore, Md		
	20 ≥ e α		23a. Part1. Enter the disease, or co	They	d the dead		March F.F				orth Av	e . Approximate	
	Physician /Medical Examiner private signs and private strausic private str	ai Examiner	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infittated events resulting in death) Last	a. AC UTE Due to (or as b. Colo (or as	VAR	y A juence of): ENS	RTER	IN FACT	SEASE			Interval Between Onset and Death MINS YEAR YEAR	
.O. DOX 00/	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Feta	I death 3	Ectopic pregnancy Other (specify)			23	3d. Date of delive	ery Day Year	
cords, r	uires that signed to Id be deta	ρ	Part II. Other significant condition	ns contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute 1 Yes 2 No 3								he cause of death?	
Dogue I	sician: The law rec certificate has bee lirector, page 2 shou	Completed							24a. Was autop perfor 1 ☐ Yes	an sy med? 2 No	24b. Were auto prior to co death? 1 \(\subseteq Yes	psy findings available impletion of cause of	
2	ician: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:		•	044		Death (Check only o	ne)			
5	Phys r this ral dir	.: To	1 ☐ Yes 2 ☑ No 27. Mannar of Death	28a. Dale of Inju		ER/Outpatier 28b. Time of		4 L (40)3111	g Home 5 Resid			(y)	
ISION OF VICES THE	nding ath. r: Afte e fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Da	y Year)	Injury		k? Yes 2 □ No					
	To the Hospital or Attending Physician: The Is within 24 Hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page:	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of In	jury - At h tc. (Specit	ome, farm, str	eet, factory, office		28f. Location (S City or Tow		Number or Run	al Route Number,	
	Hospit 24 hours Funeral letely fille	Medical (29a. Certifier 1 Certifying (Check only 2 Medical Exone)	Physician: To the best caminer: On the basis of and manner st	of examina	owledge, death	n occurred at the tin vestigation, in my o	ne, date and pla pinion, death or	ace, and due to the courred at the time,	ause(s) a date and p	and manner as solace, and due to	tated. o the cause(s)	
	To th within To th comp	Me	29b. Signature and title of certifier	////	11		29c. Licens	e number		29d. Date	signed (Month,	Day, Year)	
	1		Melice	1 /1/2	1	MD	DO	054	787	Ma	rch 1	8,2006	
	100		30. Name and address of person w	no completed causeless	Seath (Her	n 23a) (Type,	Print) MEIN	crial	Hospit	10			
b	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	rar's Signa	ature	/VIC[11	UT TECT	ותנייו	,			
	Registr	22	MAR 2 1 200	E February	M	Board	. A						

(K <mark>athy</mark> C. 06-1864 AKG	В	Unpend item# 23a,	Type or Print in PII 27 perMF State of Mary	n Black In (853 3/29 (and 7 Dep	delible	Ink. E	E nsure alth an	e All ad Me	Copies ental Hy	Are aiene	Legib	le.			
	ANG		for State Registrar			rtificate					Reg. No	11(1)	5	084	67	
	Physici	an	1. Decedent's Name (First, Middle, Las	()					2	2. Date of De Month	ath Da	у `	Year	3. Time o	f Death	
	/Medi		Kathy	C	•		rr			March	15,	2006		3:51	РМ	
	Examir	er	4a. Facility Name (If not institution, give			4b. City, To		cation of D	Death			. County of	f Death			
V	5		Maryland General 1 5. Social Security Number 6. Se		yrs. last birthday)	Baltim If Under 1		Under 24	Hrs.	3. Date of Birt		/a	9 Rinthr	lace (State	or Foreign	
5	Funeral Director			⊐м 21X1F 4			Days I	Hours !	Min.	(Month, Da	iy, Year) -56		Cour	nlace (State ontry) Mc	i.	
	with the Maryland a or 28a-f ehow be notified at	tor	10a. State 10b. County NA NA	100	. City, Town or Lo Bal	cation timore	·						1	0d. Inside C 1 XI Yes	ity Limits 2 \(\) No	
	h with the 23a or 28	al Director	10e. Street and Number 10f. Zip Code 21218								10g. Cit	tizen of Wh		ntry?		
9	72 hours after deeth with the Maryland natural; or iteme 23s or 28s-f ehow iteal Examinar must be motified at	/ Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give	Amed Forces?			Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc					White,	merican Indian, /hite, etc.		
003	72 hours "natural",	d by	3 Widowed 4 □ Divorced	Year or Dates:						Specify:		ack				
21215-0036	2 should be filed within 72 ho n and Mental Hygiene I is marked other then "natur raumatic event, the Madical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)			working	7		. Kind of Business/Industry		dustry		
		ပိ	12th grade Record Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle)								H.H.)				
Maryland	lid be lental ked o	To Be	Charlie	Н.	Bar	r		Anna					Coop	er		
ar	s 1 and 2 should 1 Health and Men 1em 27 ie marke other traumatic	-	19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (S	Street and	Number o	r Rural i	Route Numbe	er, City o	or Town, St	tate, Zip	Code)		
	and 2 ealth n 27 i		Warren Barr	Brother	Contract Con	9 Sinc		Gree							206	
ore	F of H		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	I	b. Place of Dispo cemetery, crei	sition (Name matory or othe	of er place)	į	Da	te	20c. L	ocation - C	ity or To	wn, State		
Baltimore.	t. Partmen tant:		4 □ Donation T5 □ Other (Specify		Greenmo			1	3-20			ltimo			200	
Ba	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra		21. Signature of Funeral Service Licen	9	- 22	2. Name and Marc		H. Ea	ast	1 1	altı 101	more E. No	, Ma orth	. 212 Ave.	202	
	Physician /Medical Examiner		23a. Fart 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	iperiors that caused the cause on each line. Intracerebra Due to (or as a cor	l hemorrha		of dying, s	such as car	rdiac or	respiratory ai	rrest,			Approximal Interval Bet Onset and	ween	
	rted	niner	Sequentially list conditions, in the last of the last	Due to (or as a consequence of):												
.09	be executed iicien and burial-transit	al Examin	that initiated events resulting in death) Last	Due to (or as a consequence of):												
68760	certificate be Iding physicie Ise as the bur	edic		d				***								
P.O. Box	death cer e attendin id for use	Physician/Medical	ysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ i 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic preg Other (spec						23d. Date Month		•	Year
	thet the ned by the detache	by Ph	Part II. Other significant conditions co	cant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did						23e. Did to	id tobacco use contribute to the cause of death			death?		
rds	w requires been sign should be	ed b	Cocaine use 1 □ Yes 2 🗖 No								No 3	Prob	ably 4 🗍	Unknown		
Records,	The law re sete has bee page 2 sho	Completed	<u>, </u>				-		_			Drie	or to cor	psy findings npletion of c	available cause of	
'ita	ician: Th certificete ector, pag	Be	25. Was case referred to medical examiner?				26	S. Place of	Death (Check only o		1				
of Vital		2	Yes 2□ No		2 ER/Outpatier			4 🗌 Nursir		5 ☐ Resid				()		
n C	Jing F After funera	lon:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time of Injury	28c	Work?	2 □ No	28	d. Describe t	now injui	ry occurred	1			
Division	To the Hospitel or Attending Physwithin 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, stribuilding, etc. (Specify)				2 140	28	f. Location (S City or Tov	Street an	nd Number o)	or Rura	l Route Num	nber,	
	he Hospitu n 24 hours he Funere pletely filte	Medical C	29a. Certifier (Check only one) 1 Cartifying Ph	sician: To the best of my inar: On the basis of exar and manner stated.	knowledge, deati nination and/or in	n occurred at vestigation, in	the time, o	date and p	lace, an	d due to the at the time,	cause(s)	and manr d place, an	ner as st d due to	ated. the cause(s	5)	
	To ti To ti comp	ž	29b. Signature and title of certifier	0.00	_	29c. L	icense nu	umber			29d. Da	te signed (Month,	Day, Year)		
	0		Tatu Cher	nca-tolle	hus	0.0	C.M.E				Marc	h 18	, 20	06		
1) (30 Name and address of person who o	ompleted cause of death		-	D 1			Nr. 7	,	01.000				
	-0.		31. Date filed (Month, Day, Year)	32 8/69 strar's S	1 Penn S	treet,	, Bal	timor	ce, l	Maryla	nd	21201	<u>L</u>			
	Sta Registr		31. Date filed (Month, Day, Year) WAR 2 1 20[6 America		set 1										

BRIDGEFORTH

Physicia	_	1103.01.0		00/11	neate of bt	alth and Mer		No.UUD	00403
	an	1. Decedent's Name (First, Middle, L.	ast)	0			Date of Death Month	Day Yee	3. Time of Death
/Medic		LILLIE			TLER		ARCH O	2 200	6 3:25 P.
Examin	er	4a. Fecility Name (If not institution, gr			b. City, Town, or Lo			4c. County of D	
			REOFPIKESVILLE Sex 7. Age (III			SVILLE Under 24 Hrs. 8	Date of Birth		THORE Birthplace (State or Fore)
Funeral Director			1□ M 2区F			Hours Min.	Month, Day, Ye	1905 6	Country)
) II C C (O I		Usual Residence of Decedent					14 41	100	CONGIA
how at		10a. State 10b. County	10	c. City, Town or Loca	tion			_	10d. Inside City Limi
a-1 s	tor	MARYLAND 1	VIA	X	SALTIM	IORE C	ITY		1,K)Yes 2□N
or 28	Oire	10e. Street and Number	/		10f. Zip Code		/ 10g.	Citizen of What	-
of Heelih and Menial Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-1 show other treumatic svent, the Medical Examinar mual be notified at	Funeral Directo	5705 PLAIN	IFIELD AV	ENUE	(21206	2	us	
E E	nue l	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13. Wa	s Decedent of Hisp es, specify Cuban,	anic Origin? (Specify Mexican, Puerto Rica	Yes or No- n, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
o, or in	by Fi	1 Never Married 2 Married 3 Widowed 4 Quivorced	1 Yes 2 No If Yes, Give Year or Dates:	1 [Yes 2,23,No 3	Specify:		Specify:	BIDAY
in Ex		15. Decedent's 8		16a Deceder	nt's Usual Occupation	in.	161	o. Kind of Busine	es/Industry
an and	Completed	(Specify only highest g	rade completed)	(Give kir	nd of work done duri NOT use retired)		101	o. King of Dasine	33/11/00/30/y
ther.	E C	Elementary/Secondary (0-12)	College (1-4or 5+)	Don	IESTIC	WORKER	- 1	RIVAT	E Homes
Hygi other ent, I	BeC	17. Father's Name (First, Middle, Las	st)			B. Mother's Name (Fi		den Sumame)	<u> </u>
and Mental F is marked of	To B	TOM		JONE	5	LULA			JONES
M Day	_	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing	Address (Street and	Number or Rural Ro	ute Number, C	ity or Town, State	e, Zip Code)
elth a 27 is		TAMES BUTLER	(50N)	5270	COVENTA	V ROAD	BALTI	MORE H	10.2122 or Town, State
of Heelth I Item 27 i r other tre		20a. Method of Disposition		20b. Place of Disposit cemetery, crema	on (Name of tory or other place)	Date	200	. Location City	or Town, State
nt: if ry or		1,⊠Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	Linemoval from State			NE 13-08	-06 1	DODLA	WN MARYLA
Department o important: if sny injury or pnce.	i	21. Signature of Funeral Service Lice		21 22.1	lame and Address	of Facility BRO	WATA	2 FUNE	RAL HON
Depa Impo sny ir		1 which	N. K.	nam >	140 N	FULTON	4 VE V	BALTO.	402121
		23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that caused the				spiratory arrest		Approximate Interval Between
ysician		Immediate Cause (Final	P a	Adult Fai	lure to t	hrive			Onset and Death
Medical		disease or condition resulting in death)	Due to (or as a co	onsequence of);	410				
caminer									
	Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	onsequence of).					
physicien and s the burial-transit	Examin	Cause (Disease or injury that initiated events	c						
ien a	EX	resulting in death) Last	Due to (or as a co	onsequence of):					
hysic the br	dicai		d						
attending p	0	IF FEMALE:							
ttend or us	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death 3 E	ctopic pregnancy			23d. Date of Month	delivery Day Year
ed by the a detached f	/sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at tim 9 ☐ Unknown	e of death 5 □ C	other (specify)				,
by	Ph	Part II. Other significant conditions	contributing to death but n	at resulting in the und	arlying cause given	in Part I	23e Did tohac	co use contribute	e to the cause of death
De de	>		l Insufficie						Probably 4 Winkno
5,0	0				MUV ALLES				, –
5,0	eted b			icy, coror	ary Arter				
has been sign je 2 should be	mpleted b	Disease		icy, coror	ary Arter		24a. Was an autopsy	prior	to completion of cause
ete has been sign page 2 should be	Completed by	Disease		icy, coror	ary Arter			prior death	to completion of cause
ete has been sign page 2 should be	Be	Disease 25. Was case referred to medical examiner?	Hospital:		2	6. Place of Death (C.	autopsy performed 1 ☐ Yes 2 ☑ heck only one)	d? prior death	to completion of cause 1? 'es 2 No
this certificete has been sign al director, page 2 should be	To Be	Disease 25. Was case referred to medical examiner? 1 Yes 2 No		2 ER/Outpatient	2 3 DOA Other:	4 Wursing Home	autopsy performed 1 Yes 2 heck only one) 5 Residence	Prior death 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	to completion of cause 1? 'es 2 No
n. After this certificete has been sign funeral director, page 2 should be	To Be	Disease 25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day Ye	2 ER/Outpatient	28c. Injury at Work?	4 Nursing Home 28d.	autopsy performed 1 Yes 2 heck only one) 5 Residence	d? prior death	to completion of cause 1? 'es 2 No
n. After this certificete has been sign funeral director, page 2 should be	To Be	Disease 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner ol Death 1 Matural 5 Pending investigate 2 Accident 5 Culd not	28a. Date of Injury (Month, Day Ye	2 ER/Outpatient 28b. Time of Injury	28c, Injury al Work?	4 Nursing Home 28d. s 2 No	autopsy performer 1 Yes 2 [2] heck only one) 5 Residence Describe how	e 6 Other (S	to completion of cause (/es 2 No
n. After this certificete has been sign funeral director, page 2 should be	To Be	Disease 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending investigate	28a. Date of Injury (Month, Day Ye	2 ER/Outpatient 28b. Time of Injury - At home, farm, stree	28c, Injury al Work?	4 Nursing Home 28d. s 2 No	autopsy performer 1 Yes 2 [2] heck only one) 5 Residence Describe how	or or death of the control of the co	to completion of cause of 1? 'es 2□ No
n. After this certificete has been sign Iuneral director, page 2 should be	Certification: To Be	Disease 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending investigate 5 Could not determine	28a. Date of Injury (Month, Day Ye do do do do do do do do do do do do do	2 ☐ ER/Outpatient 28b. Time of Injury - At home, farm, stree Specify)	28c. Injury at Work? M 1 Yest, factory, office	4 PNursing Home 28d. s 2 No 281.	autopsy performer 1 Yes 2 (E- heck only one) 5 Residenc Describe how Location (Street City or Town, S	e 6 Other (Sinjury occurred	to completion of cause (2) Yes 2 No Specify) Rural Route Number,
n. After this certificete has been sign Iuneral director, page 2 should be	Certification: To Be	Disease 25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day Ye building, etc. (S) Physician: To the best of marminer: On the basis of ex	2 ER/Outpatient 28b. Time of Injury - At home, farm, stree Specify) ny knowledge, death of amination and/or inve-	2 3 DOA Other: 28c. Injury at Work? M 1 Yes	4 PNursing Home 28d. s 2 No 28l. date and place, and	autopsy performed to the cause of the cause	e 6 Other (Sinjury occurred	or completion of cause of completion of cause of completion of cause of completion of cause
n. After this certificete has been sign Iuneral director, page 2 should be	To Be	Disease 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner ol Death 1 Matural 5 Pending investigate 3 Suicide 4 Homicide 6 Could not determine	28a. Date of Injury (Month, Day Ye building, etc. (s)	2 ER/Outpatient 28b. Time of Injury - At home, farm, stree Specify) ny knowledge, death of amination and/or inve-	2 3 DOA Other: 28c. Injury at Work? M 1 Yes	4 Wursing Home 28d. 5 2 No 28l. date and place, and ion, death occurred a	autopsy performed autopsy performed to the cause the the time, date	e 6 Other (Sinjury occurred	to completion of cause of completion of cause of completion of cause of completion of cause of completion of cause of ca
ours after death. Ieral Director: After this certificete has been sign filled in by the funeral director, page 2 should be	edical Certification: To Be	Disease 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending investigath 3 Suicide 4 Homicide Could not determine 29a. Certifier (check only one) 29b. Signature and title of certifier	28a. Place of Injury (Month, Day Ye de la Company) 28e. Place of Injury building, etc. (See Physician: To the best of maminer: On the basis of example and manner stated	2 ER/Outpatient ear) 28b. Time of Injury - At home, farm, stree Specify) ny knowledge, death of amination and/or investige.	2 3 DOA Other: 28c. Injury at Work? M 1 Yes t, factory, office ccurred at the time, stigation, in my opin 29c. License n	4 I Nursing Home 28d. s 2 No 28l. date and place, and ion, death occurred a	autopsy performed autopsy perf	e 6 Other (Sinjury occurred	res 2□ No Specify) Formal Route Number, reas stated, due to the cause(s) onth, Day, Year)
n. After this certificete has been sign Iuneral director, page 2 should be	edical Certification: To Be	Disease 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Matural investigate 3 Suicide 4 Homicide 29a. Certifier (Chack only one) 29b. Signature and title of certifier Mature K.	28a. Date of Injury (Month, Day Ye) 28e. Place of Injury building, etc. (See Physician: To the best of maminer: On the basis of exand manner stated	2 ER/Outpatient 28b. Time of Injury - At home, farm, stree Specify) ny knowledge, death o amination and/or inve-	28c. Injury at Work? M 28c. Injury at Work? I Yest, factory, office ccurred at the time, stigation, in my opin 29c. License n	4 Wursing Home 28d. 5 2 No 28l. date and place, and ion, death occurred a	autopsy performed autopsy perf	e 6 Other (Sinjury occurred	to completion of cause of 2 Yes 2 No Specify) Frank Route Number, Tas stated. Jue to the cause(s)
n. After this certificete has been sign Iuneral director, page 2 should be	edical Certification: To Be	Disease 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending investigath 3 Suicide 4 Homicide Could not determine 29a. Certifier (check only one) 29b. Signature and title of certifier	28a. Date of Injury (Month, Day Ye (Month, Day Ye) 28e. Place of Injury building, etc. (A parties) Physician: To the best of maminer: On the basis of ex and manner stated Completed cause of death	2 ER/Outpatient 28b. Time of Injury - At home, farm, stree Specify) ny knowledge, death o amination and/or inve- 1.	2 3 DOA Other: 28c. Injury at Work? 1 Yest, factory, office courred at the time, stigation, in my opin 29c. License in	date and place, and ion, death occurred a sumber	autopsy performed autopsy perf	e 6 Other (Sinjury occurred and Number or late) e (s) and manner and place, and of the signed (March 3)	res a stated. due to the cause(s) onth, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician**)CI /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner enbuenie Health & 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Months 1 M 2 D Hours 231-50-0858 88 Yrs Director RICHMOND Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State 27 Is marked other than "natural", or Itams 23a or 28a-f shov traumatic event, the Medical Exeminat must be notified at 1 Yes 2 No Director MD Anne Arundel Glen Burnie the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? should be filed within 72 hours after death with t nd Mental Hygiene. marked othar than "natural", or Itams 23a or 2 7355 E. Furnace Branch Road 21060 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Tyes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Amarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Robert Beale Watkins Mame Messersmith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) itam 27 204 Greenwood Road Linthicum, MD 21090 Marvin A. Bond, son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 03/19/06 Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee George MacNabb Xer2 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** phas1a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed burial-transit HTIN Due to (or as a consequence of): physician Physiclan/Medical the t IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year for in the past 12 monthe? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) the i o 9 Unknown ۵ σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ģ 99 UICEVS 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy performed Thrombocytosis certificate | 2 No 1 ☐ Yes of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 1 Tes 2 No 3□ DOA 2 SIL funeral 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: Division or Attanding Injury 1 Natural 5 Pending investigation death. 1 | Yes 2 | No 2 Accident Diractor: the 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 - Homicide Hospital 24 hours a ↑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 the

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

PURVI 31. Date filed (Month, Day, Year)

MAR 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

7

ORIGINAL

7445

32. Registrar's Signature

29c. License number

H0061312

FURNACE

29d Date signed (Month, Day, Year)

06

21066

			For State Registrar	State of Ma	aryland / Dep	artment of rtificate of			_	gien	HIII	0847	The same of the sa
0			Decedent's Name (First, Middle, La	st)				2	2. Date of De	ath		3. Time of D	eath
	hysici: /Medic		JOSEPH A. BA	KER, Jr.				M	Month arch	13.	y Yea 2006	7:15 ar	n M
	xamin		4a. Facility Name (If not institution, giv	e street and number)	- 1 C	4b. City, Town,		of Death		40	County of De	ath	
			Univ. of Maryla			Balti					N/		
	neral		5. Social Security Number 6. S	ex 7. Age ∏x M 2 ☐ F	(In yrs. last birthday 89 Yrs.	If Under 1 Year Months Days		Min.	B. Date of Bir (Month, Da Nov • 5	th ly, Year 1	9. B	irthplace (State or a Country)	Foreign
Dir	ector		196 09 3410 Usual Residence of Decedent		09			1	NOV. 3	, 15	916 P	ennsylvar	nia
yland	Mo ta		10a. State 10b. County		10c. City, Town or L	ocation						10d. Inside City	Limits
Mar	iffied	ctor	Maryland Anne A	rundel	Baltim	ore						1 ☐ Yes 2	2 🔯 No
E E	OF 28	Director	10e. Street and Number			10f. Zip Code				10g. Ci	tizen of What (Country?	
ath w	1238 MBI L	ral	5420 Wasena Av				1225				U.S.		
d Z Z 5-UU30 filed within 72 hours after death with the Maryland Hygiene.	r Items nimer m	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 \(\text{Yes} \) 2 \(\text{Z} \text{N} \)	Ever in U.S. 13.	Was Decedent of If Yes, specify Cul			ify Yes or No can, etc.)	-	14. Race - An Black, Wh	ite, etc.	
2-0030	Exal.	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify	r:			Specify: W	nite	
72 h	Clical	Completed	15. Decedent's E (Specify only highest gra		16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retire	pation during mo	st of working	7		ind of Busines	-	
within Nie	nan Ir Mik	Idm	Elementary/Secondary (0-12) 12th	College (1-4or 5-		<i>DO NOT u</i> se retir hinist	ed)				ethlehe ilroad	m Steel	
illed wi	nt, III	ပိ	17. Father's Name (First, Middle, Last				18. Moth	er's Name (First, Middle,				
Maryland d 2 should be fill th and Mental Hy	C eve	To Be	Jose	oh A. Baker	r, Sr.				beth V		. comano,		
shoul of M	лат глаті	F	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ng Address (Stree	t and Numb	er or Rural f	Route Numb	er, City	or Town, State,	Zip Code)	
ind 2 alth a	er tre		Robert Baker / S	Son	600	O Califor	rnia (Circle	#304	Roo	ckville	, MD. 208	352
es 1 a	r othe		20a. Method of Disposition	10 Ot-t-	20b. Place of Disp cemetery, cre	osition (Name of matory or other pla	ace)	Dat	te	20c. L	ocation - City o	r Town, State	
Page ment	ury or		1 ☑Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specif		Holy Cro		· ·	3/16/2	2006	Ba1	timore	Marylan	d
Datitinore, Intalyliation ZIZI3-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.	any inj		21. Signature of uneral Service Licer	nsee A	11	2. Name and Addr		GOI.	nce Fu	nera timo	1 Servi	ice, P.A.	225
	= 0		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. onot en			77-57-50-50-50-50-50-50-50-50-50-50-50-50-50-				Approximate Interval Between	
Phys	ician		Immediate Cause (Final disease or condition		Intracra	nial He	morr	hage				Onset and De	
	dical		resulting in death)	Due to (or as a	a consequence of):			gc				5 Days	-
Exan	niner		Secuentially list conditions	Pneumo	7251							3Days	
/ Pe	sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence of):								
көсир	I-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	a consequence of):								
certificate be executed	pnysician and s the burial-transit	icalE											
ificate	as the			d									
The law requires that the death cert	been signed by the attending prishould be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 24 Pregnant at 19 Unknown	2 ☐ Fetal death 3	□Ectopic pregnand □ Other (specify) _	су				23d. Date of d Month	elivery Day Ye	ar
that	deta		Part II. Other significant conditions of	ontributing to death bu	at not resulting in the a	inderlying cause g	ven in Part	I.	23e. Did to	obacco	use contribute	to the cause of dea	ath?
w requires	old blu	ed by			.				10	Yes 2	Дио з□1	Probably 4 Uni	known
	0 01	oleted							24a. Was		24b. Were a	utopsy findings av	ailable
The la	ral director, page 2 s	Comple							autop perfo	osy rmed? 2 2 No	prior to death?	completion of cau s X No	se of
	tor, p	BeC	25. Was case referred to medical				26. Plac	e of Death (6	Check only o		1010	5 <u>F</u>	
Physic	0 0	To	examiner? Xi Tyes 2 No	Hospital: Inpatier		nt 3 DOA	her: 4□N	ursing Home	5 🗆 Resid	dence	6 □Other (Sp	ecity)	
ding P	funeral	Certification:	27. Manner of Death	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	Wo	ıryat ork?]Yes 2.⊑		d. Describe f	now inju	ry occurred		
Atten	by the	ifica	3 Suicide 6 Could not b	e 28e. Place of Inju	ry - At home, farm, st	reet, factory, office		281				Rural Route Numbe) <i>I</i> ',
s afte	ed in	Cert	4 Homicide	building, etc.	. (Ѕресіту)				City or Tov	vn, State	9)		
To the Hospitel or Attending Physicien: within 24 hours after death.	completely filled in	edical	29a. Certifier (Check only one) Certifying Ph	ysician: To the best o niner: On the basis of and manner stat	examination and/or in	h occurred at the t vestigation, in my	ime, date a opinion, de	nd place, and ath occurred	d due to the at the time,	cause(s date an) and manner a d place, and du	is stated. le to the cause(s)	
To the within	woo l	Ž	29b. Signature and title of certifier	12	V 0		se number			29d. Da	te signed (Mor	nth, Day, Year)	
	t	15	1 011/40	The		17099	9			Mar	ch 15,	2006	
	10		30. Name and address of person who Michael J. Kilb	ompleted cause of de		Greene	Stre	et, I	Balti	mor	e, Md	21201	
. –	Sta		31. Date filed (Month, Day, Year) MAD 9 1	32. Pagistra							-		
DHMH 17	Rev 1/20	1,2	MAR 2 1 2	.000 Jacks	urs Signature	400							

_			1 - For State Registrar	State of Ma	-	artment ertificate			and M		ieņe 99. No. 0 0 () (08472
	Physic		1. Decedent's Name (First, Middle, Last)	Bock						2. Date of Deat	6, Day 2006 Y	ar	3. Time of Death 12:45 a _M
J.	/Medi Examir		4a. Facility Name (If not institution, give s Gilchrist Cente			Т	owsc				4c. County of Balt		re
	Funeral Director		377-10 0010 ,	7. Age	(In yrs. last birthda 94 Yrs.	Months Months	Year_ Days	If Under 2 Hours	Min.	8. Date of Birth	5 ⁷ ,ea ⁷ ,1911	Birthpl CP/1	ace (State or Foreign 취급
	Maryland	tor	Usual Residence of Decedent	Į.	10c. City, Town or	ccation keysvi	lle					10	od. Inside City Limits 1 ☐ Yes 2 💢 No
	h with the 23a or 28 st be not	Funeral Director	10e. Street and Number 801 Staffordshir	re Road		10f. Zip (² 10	30		10	Og. Citizen of Wha		ry?
980	s 1 and 2 should be filed within 72 hours after deeth with the Maryland f Health and Mental Hygiene. Item 27 is marked other then "netural", or Iteme 23a or 28a-f show other traumatic event, the Wadical Experimet must be notified at	6	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	ver in U.S. 13	. Was Decede If Yes, speci 1 \(\text{Yes} \) 2		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	14. Race - Black, 1 Specify:	White, e	
21215-0036	d within 72 ho giene. er then "netur , the Medicel	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12	cation o completed) College (1-4or 5+	(Giv	edent's Usual re kind of work DO NOT use IET	done di	uring most	of worki	ng	16b. Kind of Busin Resta		
Maryland	should be filed withir and Mental Hygiene. Is marked other then sumatic event, the Ms	To Be C	17. Father's Name <i>(First, Middle, Last)</i> Dan	Bock					r's Name (im	(First, Middle, N Kun Le	faiden Sumame) e		
	1 and 2 sho Health and I em 27 is me ther traums		19a. Informant's Name/Relationship (Ty			-					City or Town, Sta		^{Code)} 21 030
Baltimore,	Pege nent o int: If iry or		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of Dis cemetery, cr Dulaney	Valley			3/20,	/06	20c. Location - Cit Timoniu	ım, I	MD
Balt	permit. Depertn Imports any Inju		21. Signature of Funeral Service License	⇔ William	G. Dau					ck Towso son, MD	n Funera 21204	1 H	ome, Inc.
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	SCN). 	nter the mode				r respiratory arre	est,		Approximate Interval Between Onset and Death
8760, 中	rate be executed by the burial-transit	cal Examiner	Sequentially list conditions, If any, leading to infunctions cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last		consequence of):								
P.O. Box 68	ne death certific the attending p thed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1∐Live birth 2 4∐Pregnant at ti 9∐Unknown	Fetal death 3	□Ectopic pre					23d. Date o Month		y Day Year
	quires that the signed by ald be detacted	Ď	Part II. Other significant conditions cor	tributing to death but	not resulting in the	underlying ca	use give	n in Part I.		23e. Did tob	acco use contribu		e cause of death?
Vital Records,	iiclan: The law requir certificete hes been si rector, page 2 should t	Completed								24a. Was ar autopsy perform 1 Yes 2	prior dear	to com	sy findings available ipletion of cause of
of	ding Phys J. After this funeral di	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Peath SNatural 5 Pending investigation	ospital: 1 Inpatient 28a. Date of Injury (Month, Day)			Other c. Injury Work	^C 4□Nui	rsing Hor	Check only one ne 5 Resider Re		Specity	nopie
Division	al or Attendii s after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, s (Specify)	treet, factory,	office		2	28f. Location (Str City or Town	reet and Number o , State)	r Rural	Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check orthy one) Medical Examir	ician: To the best of er: On the basis of e and manner state	xamination and/or	nth occurred a	the time	e, date and inion, deat	d place, a	and due to the ca	use(s) and manne ite and place, and	or as sta	ited. the cause(s)
	To the within 2 To the comple	Ž	29b. Signature and title of certifier	Mus	>		License	number 83c	13		od. Date signed (A		
	8		30. Name and address of person who co	mpleted cause of dea		e, Print)	Sr	18	ton	we d	0 2126	7	
	Sta Registi		31. Date filed (Month, Day, Year) MAR 2 1 20	32. Begistrar	's Signature	nock s						1	

ORIGINAL

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature/and title of contifier

30. Name and address of person who completed cause of peath (Item 23a) (Type, Print)

2006 MAR 2

29c. License number

111 Penn Street

OCME

29d. Date signed (Month, Day, Year)

March 13, 2006

Baltimore, Maryland 21201

			For State	State of Maryla	and / Dep	artment of H	lealth and M	-	•	N year gr	0171
	. * 3.6	ý.	Registrar 1. Decedent's Name (First, Middle, Las	t)	Ce	rtificate of	Death	2. Date of Dea	leg. No. U ↓ ith		3. Time of Death
	Physici		Christine		beall	•		o ^{Month}	Day	2006	2=154M
	/Media Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death			y of Death	
No.	35)		Southern Maryla		an front block t		inton If Under 24 Hrs.	0.0 1. (0.1)			orge's
	Funeral Director		5. Social Security Number 6. Sec	AX 7. Age (in yi	rs. last birthday, Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Sept	4, 192	9. Birthpla Counti 5 Mary	ace (State or Foreign Y) Land
	aryland ehow	-	10a. State 10b. County		City, Town or L					10	d. Inside City Limits
:	28a-f	Funeral Director	Maryland Prince (jeorge's	Upper M	farlboro,			10- 02	14/5-1-0	1 ☐ Yes 2 ☐ No
	with with	Ö	14615 Crescer	nt Drive P O	BOX263		7.2		10g. Citizen of		•
	death ma 23	nera	11. Marital Status	12. Was Decedent Ever in		Was Decedent of H If Yes, specify Cuba		ecify Yes or No-		ted St	n Indian,
215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland It health and Mental Hygiene. Item 27 is marked other than "neturell, or Itema 23a or 28a-f ehow other treumatic event, the Medical Exenting in this be malified at	b	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ∐Yes 2 ThNo If Yes, Give XX Year or Dates:		1 ☐ Yes 2☐√No	Specify:	Hican, etc.)	Speci	ack, White, e	hite
20	72 ho	etec	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of work	ing	16b. Kind of 8	Business/Indi	ıstry
121	within ane. Ithen	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired etary	1)		Mary 1	Ware	house ates Tabac
N	Hygie Hygie ont,		17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,			aces labac
an	buld be Mental arked c	To Be	Richard Sweene	y				Grace	Taymer	n	
Maryland	2 should and Men is marke eumatic	1	19a. Informant's Name/Relationship (T		1	ng Address (Street	and Number or Rura	al Route Numbe	r, City or Town	, State, Zip (Code)
	and iealth im 27 her tr		Richard Wines,	Sr. (Nephew)	16	601 Notti	ngham ROa	d. Uppe	r Marl'	oro, l	10 20772
20	90 = 5		20a. Method of Disposition 1 ABurial 2 Cremation 3	Removal from State	cemetery, cre	osition (Name of matory or other place	^{e)} March 21	, 2006	20c. Location	•	
Baltimore,	Sermit. Pag Separtment mportant: Iny Injury o		4 □Donation 5 □ Other (Specify, 21. Signature of Funeral Septice License	S	t Thoma	S Croom C 2. Name and Addres	emetery		Upper M	laribo	ro, MD
Ва	Depa Impo		1/1/1/1/1	h 12015	-3 A	lexandria	Ferry Ro	ad. Cli	т поше, nton. M	inc. 1D 2071	0033 UIA
	* .		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	lications that caused the de							Approximate Interval Between Onset and Death
100	hysician /Medical		disease or condition resulting in death)	a. Heart Due to (or as a cons	equence of):	we-					
	Examiner		Sequentially list conditions	Respir	atory	Fail	lure_				
	p H	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (ur - a con	equence of).	Fail		. 10	MI	-1	•
_	be executed sicien and burial-fransit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a con	quence of):	avun	ono	WITH		3/ 40/	/
760,	sicien Sicien Duria	caiE		Sep	cil						
687	ificate g physas the			a							
.O. Box	The law requires that the death certificate be executed ite has been signed by the attending physicien and bage 2 should be detached for use as the burial-fransit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3[□Ectopic pregnancy □ Other (specify)				ate of deliver onth E	y Day Year
٦.	res that the de igned by the a be detached to		Part II. Other significant conditions co	entributing to death but not r	resulting in the u	inderlying cause give	en in Part I.	23e. Did to	bacco use con	tribute to the	cause of death?
rds	quires n sign uld be	Completed by	Cardiac	Arryth	amia	<i>/</i> .		1 🗆 Y	es 2 No	3 🗌 Proba	bly 4 DUnknown
Records,	aw require is been sig 2 should b	piet	Deural	etturin		_		24a. Was a		Were autops	sy findings available
		E O		11 00				autop: perfor	med? 2 No	death?	pletion of cause of ≧□ No
Vital	Physician: The this certificate har ral director, page	Be (25. Was case referred to medical examiner?		75		26. Place of Death				
- to	-	은	1 Yes 2 No		☐ ER/Outpatie		4 Nursing Ho				
uc	After Atter funer	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	y at k? Yes 2 □ No	28d. Describe h	ow injury occu	rred	
Division	I or Atten after deat Director: I in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	1	t home, farm, st ecify)			28f. Location (S City or Tow	treet and Num n, State)	ber or Rural	Route Number,
	To the Hospital or Attending F within Z Hours after death. To the Funeral Director: After completely filled in by the funer.	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	/sicien: To the best of my k iner: On the basis of exami and manner stated.	knowledge, deal ination and/or in	th occurred at the tin	ne, date and place, pinion, death occurr	and due to the ded at the time, o	ause(s) and m late and place,	anner as sta , and due to t	ted. he cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	1. 10	Silv	29c. Licens			9d. Date signe		
	\mathcal{A}_{i}		20 Name and address of access the	completed cause of death (1)	tom 220) (Time	Print)	7 1 1	-	2111	612	woldock
	10		30. Name and address of person who of ABDEL ACCOUNTY. 31. Date filed (Month, Day, Year)			32610	ld wash	ington	. Rd#	=10/2 Md,	20602
	Sta Registi		MAR 2 1 2	32. Begistrar's Sig	K A	Could t					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#8, perFig. 854, Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 12.25M Bridge 06 Edmund 03 /Medical 4c. County of Death 4a. Facility Name (If not igstitution, give street and number) 4b. City, Town, or Location of Death Examiner University of Mangand Medical Baltimore City none If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 17, June 12, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 ☐ F Min. Hours .9194 12 Director Oklahoma Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "netural", or items 23a or 28a-f ehow other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Elkridge Howard Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21075 U.S.A Funeral 6170 Lawyers Hill Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or ite may injury or other traumatic event, the Medical Examine and. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry defense contracting Elementary/Secondary (0-12) College (1-4or 5+) engineer 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be ٥ Eva Konkel George Bridge 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6170 Lawyers Hill Road Elkridge, Maryland 21075 Ms. Marguerite S. Bridge
20a. Method of Disposition Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/15/2006 Baltimore, MD Bayview Crematory 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final) CERTIFICATION APPROVED BY MEDICAL EMMINIS Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cervical **Physician** SPINAL 5 clays /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in titated events resulting in death) Last Due to (or as a consequence of): Examine anding physician and use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death 28b. Time of Injury motor vehicle crash 1 □Natural 5 Pending 4:48PM 19/06 1 🗌 Yes investigation 2 Accident completely filled in by the 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 97 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Division of Vital Records, P.O. Box 68760,

death with the Maryland

Baltimore, Maryland 21215-0036

30. Name and a dress of person who completed ca of death (Item 23a) (Type, Print) au 31. Date filed (Month, Day, Year) MAR 2 1 legistraf's Signature 2006

29b. Signature and title of certifier

State

Registrar

29c. License number

29d. Date signed (Month, Day, Year)

	1	For State Registrar		aryland / Depa		ealth and	Mental Hy	giene	8476
Physicia	-	1. Decedent's Name (First, Middle, Las					2. Date of De.	Day Year	3. Time of Death
/Medica	al -	Martha Kay Bovene a. Facility Name (If not institution, give			4b. City, Town, or	Location of Deat	March	9 2006 4c. County of Death	11.4/ M
Examine	er	10816 Livingston	_		Fort Was			Prince Geo	orae
Funeral	- 1	5. Social Security Number 6. Se	7. Age	(In yrs. last birthday)		If Under 24 Hrs Hours Min.	8. Date of Bir	th 9 Rights	lace (State or Foreign
Director		216-40-5308 Usual Residence of Decedent	□M 2 5 F	62 Yrs.		110010	08/16/1	943 Mary	land
fand 10w	-	10a. State 10b. County		10c. City, Town or Lo	ocation			1	0d. Inside City Limits
a-f of	cto I	Maryland Prince G	eorge	Fort Wash	ington				1 Tyes 2 No
vith th	<u> </u>	10e. Street and Number			10f. Zip Code 20744			10g. Citizen of What Cour United State	
eath v	erai	10316 Livingston R	12. Was Decedent 8	Ever in U.S. 13.		ispanic Origin? (S	Specify Yes or No		
	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	lo.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	n, Mexican, Puer Specify:	to Rican, etc.)	Black, White, Specify: Whi	
2 hour	ted t	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	ation	adeiro a	16b. Kind of Business/In-	
e n "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5	+)	kind of work done of DO NOT use retired	during most of wo	rking		
Nygien H, th	် ပ	12		Haird	resser	19 Mother's Na	me (First Middle	Cosmotology Maiden Sumame)	
yiallo	m	17. Father's Name (First, Middle, Last) Ephie Aldon Boven	der			Verlie		, маюні зипапне)	
2 should and Me ls mark aumatic	၉	19a. Informant's Name/Relationship (7		19b. Maili	ng Address (Street			er, City or Town, State, Zip	Code)
	1	Louise Vestol - S	ister		Hwy 601 N		onville,	NC 27018	
of He or other		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	20b. Place of Disponentery, cre	osition (Name of matory or other place		Date	20c. Location - City or To	
Deficient Pages Department of mportant: If it any injury or one	-	4 ☐ Donation 5 ☐ Other (Specify	"		e Cemeter			Boonville, N	
Dallimore, IVI permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny injury or other tra page.		21. Signature of Funeral Service Licen	De ber C	FSP I	Payid J. N 101 S. Cos	Weber Fu ester St	neral Ho reet Bal	mes P.A. timore, Mary	land 21231
Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each lin	10.				Heart Dis	Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)		a consequence of):	.,				
uted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	a consequence of):					
e be executed sicien end burial-transit	cal Exar	resulting in death) Last	CDue to (or as	a consequence of):					
g physicate I		**	d						
wrequires that the death certificate be executed been signed by the attending physicien end should be detached for use as the buriat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth 4□Pregnant at	2 Fetal death 3	⊒Ectopic pregnancy ⊒ Other (specify)	,		23d. Date of delive Month	ery Day Year
the day the ached	hysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown						
law requires that as been signed b	þ	Part II. Other significant conditions of	ontributing to death be	ut not resulting in the I	underlying cause giv	en in Part I.		tobacco use contribute to t Yes 2 ☐ No 3 ☐ Prot	
law requires as been sign	Completed						24a. Was	psy prior to co	ppsy findings available mpletion of cause of
VICAL MEC sician: The law certificete has b irector, page 2 s	Con						1 ☐ Yes	ormed? death? 2 No 1 Yes	2 No
Physician: This certifice	o Be	25. Was case referred to medical examine? 1. ✓ es 2 □ No	Hospital:	ant 2 C C P/Outpotio	oth all pool Oth	OF:	Hama 5 200	one) dence 6 ⊡Other (Specil	6.1
ing Phys	on: T	27. Manns of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Day	rv 28b. Time	of 28c. Injur	v at		how injury occurred	у)
UNISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certificati	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ury - At home, farm, si c. (Specify)				Street and Number or Rura wn, State)	al Route Number,
Hospital or 24 hours afte Funeral Dir tely filled in	Medical Co		niner: On the basis of	f examination and/or ii				cause(s) and manner as s date and place, and due t	
ro the within 2	Mec	29b. Signature and title of certifier	and manner sta	2.0U.	29c. Licens	e number		29d. Date signed (Month,	Day, Year)
⊢≯⊢ŏ		1 Salvado	13203	to Do	Ho	5592	7	MARCA 1.	3, 2006
4	+	30. Name and address of person who	completed cause of d	leath (Item 23a) (Type	Print)				1
1 1		SALVALOR Shi	Jer 300	1 Hospit	al Din	e Che	everle	Man law	d

			1 - For State Registrar	State of Maryland	•	irtment of H			giene eg. No. 005	08477
			Decedent's Name (First, Middle, Last	1)				2. Date of Deat	th	3. Time of Death
	Physici /Medic		CARL FREDER	ICK BRETALL				March	Day Yea 18,2006	12:30 AM
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or		1	4c. County of De	
			3506 Quatman A			Ba 1	timore		Balti	
	Funeral Director		5. Social Security Number 6. S 214-30-5311	ex 7. Age (In yrs. la X M 2□F 72	St birtnday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Sept. 20,	9. 8 933 Ma	irthplace (State or Foreign Country) ryland
		ĺ	Usual Residence of Decedent	, ,				pepe. 207	700	-1-4114
	nylan show		10a. State 10b. County		Town or Lo	cation				10d. Inside City Limits
	8a-f s	cto		imore	Bal	timore				1 □ Yes 2√ No
	with the	Funeral Director	10e. Street and Number	Arranua		10f. Zip Code	4	1	Og. Citizen of What	Country?
	eath	erai	3506 Quatman 11. Marital Status	12. Was Decedent Ever in U.S	. 13. v	2123		pecify Yes or No-	USA 14. Race - Ar	nerican Indian.
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Healith and Menial Hygiens. f Healith and Menial Hygiens inten 27 Is marked other then "neturel", or Items 23e or 28e-f show other treumatic event, the Medical Examinating Legical and	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? ↑☐Yes 2☐No If Yes, Give Year or Dates:	i	Vas Decedent of Hi i Yes, specify Cubar I ☐ Yes 25 No	Specify:	o Rican, etc.)	Black, Wi	
5-0	72 ho inetui	Completed	15. Decedent's Ed (Specify only highest gra		(Give	lent's Usual Occupa	luring most of wor	king	16b. Kind of Busines	s/Industry
121	within ane.	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		ness Ma			Sheet Metal	Workers Union
N	filed withir Hygiene. other then ent, the M		12 17. Father's Name (First, Middle, Last)					ne (First, Middle, I	Maiden Sumame)	
Maryland	and Mental and Mental is marked o	To Be	Frederick L	ouis Bretall			Bertha	Elizak	oeth Hill	perg
ary	2 should and Men Is marke		19a. Informant's Name/Relationship (7	** * *					r, City or Town, State	
	item 27	-	Mona-Lee Breta			-	venue Ba		Maryland 2	
altimore,	nit. Pages 1 artment of H ortent: If iter injury or oth		20a. Method of Disposition Disposition Gramation 3 Other (Specify	Removal from State	wood (sition (Name of natory or other place Cemetery	Mar.2	2,2006 P	arkville,	Maryland
Burial 2 Cremation 3 Removal from State Parkwood Cemetery Mark Parkwood Cemetery Mar								NS CHAPE ad-Park	L OF MEMOR	RIES 21234
			23a. Part1. Enter the disease, or companies shock, or heart failure. List only	plications that caused the death, one cause on each line.	Do not ente	er the mode of dying	g, such as cardiac	or respiratory arm	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Atherosci	Yor	(Breli	ovacu	Very Oil	Jour	Onset and Death Heors
	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of)	Da Port	131 h	101:4g	Λ	
	Ñ	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseque	ence of):	ricelle	of the	eci, co		geore
	s be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c						
0,	e exection are are urial-to	Exc	resulting in death) Last	Due to (or as a conseque	ence of):					
8760,	ate hy:	dical		d						
		/Me	IF FEMALE:	23c. If yes, outcome of pregnan	cv				Old Date of d	
Вох	leath of attendant of for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea	death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of d Month	Day Year
O.	that the de ed by the detached	hysi	9 Unknown	9☐ Unknown		,				
ecords, P	se us	þ	Part II. Other significant conditions o	ontributing to death but not resul	ting in the ur	nderlying cause give	en in Part I.			to the cause of death? Probably 4 Unknown
00	aw requir ts been si 2 should	Completed						24a. Was a		autopsy findings available completion of cause of
		Mo						autops perforr	med? death?	
Vital	ysicien: The is certificate director, pag	Be (25. Was case referred to medical examiner?					th (Check only on	ne)	
of \	hys this al dii	2	1 Yes 27 No		R/Outpatien		4 Nursing H	· · · · · · · · · · · · · · · · · · ·	ence 6 Other (Sp	pecify)
	ding After fune	tion	1 ■ atural 5 Pending	(Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 □ Y	at :? /es 2 □ No	W/A	ow injury occurred	
Division	or Attending after death. Director: Afte in by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injury - At hon	ne, farm, stre			28f. Location (St	reet and Number or i	Rural Route Number,
D		Certification:	4 Homicide	building, etc. (Specify)				City or Towr	n, State) N/A	
	To the Hos, itel or within 24 hours after To the Funcrel Dir completely filled in	edical (29a. Certifier (Check only one)	ysician: To the best of my know niner: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the tim restigation, in my op	e, date and place, pinion, death occur	, and due to the carred at the time, d	ause(s) and manner ate and place, and di	as stated. ue to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	n)		29c. License	number	2	9d. Date signed (Mo.	nth, Day, Year)
•	1 W		I July B.	ly		D29	601		3-20-	06
Į.	27		30. Name and address of person who	company pul	23a) (Type, I	Print)	00/477-61	ZIV PM	W/ Bet	21206
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 1 20	Se riegistiai s Signate	ire Andrew	de				

RΥ	BANBRID	GE '	1 - For State Ragistrar	•	epartment of Health and I	Mental Hygiei	211115	08478
			Decedent's Name (First, Middle, Las			2. Date of Death		3. Time of Death
	Physicia		Mary Mas	THA BAINGE	7.01.0	MARCH 1	7, 2006	1700 P M
	/Medic		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of Death	1700 1
	Examin	er	UPPER CHESAPEAKE		BEL AIR		HARFORD	
	Funeral		5. Social Security Number 6. Se		Iday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye		place (State or Foreign
	Director		217-86-7046 1	JW 580 E 7777 A	rs. Months Days Hours Min.	FEG. 17 10	ar) Coui	2/2
			Usual Residence of Decedent				1001 11 11 11	Z/A:M R
	ylan		10a. State 10b. County	10c. City, Town	or Location		1	0d. Inside City Limits
	Ma-f-	ᅙ	CARRED HARFE	ORO BELL	Air			1 ☐ Yes 2-12 No
	in the	e e	10e. Street and Number	_	10f. Zip Code	10g.	Citizen of What Cour	ntry?
	th will	Funeral Director	103 APT. 20 TOL	EWILD DRIVE	21014		V.S.A.	
	dea	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- lo Rican, etc.)	14. Race - Americ Black, White,	
9	or It	E	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give	1 ☐ Yes 2 No Specify:		Specify:	
5-0036	hours after death with the Maryland tural', or Items 23a or 28a-f ehow al Examiner must be nutified at	d by	3 Widowed 4 Divorced	Year or Dates:	•		W	HITE
5	72	Completed	15. Decedent's Ed (Specify only highest gra-	de completed)	Decedent's Usual Occupation (Give kind of work done during most of work)	rking 16b	. Kind of Business/In	dustry
121		m m	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)	7	a 0	0
2	e filed v al Hygie I other t vent, ib	ပိ	17. Father's Name (First, Middle, Last)	4 316	18 Mother's Nar	ne (First, Middle, Maid	der Sumama)	<i>y</i> .
E	be fi	Be	17. Father's Name (First, Middle, Last)	11 = 1	10. Motifier 3 (4a)	THE (THISE, TWIDDIE, TWIATE	a l	
Ĕ	2 should be and Mental is marked o	7	19a, Informant's Name/Relationship (7	LAICKO	Mailing Address (Street and Number or Ru	J. J.	ECKINS	Code) 2/028
Maryland	s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the M		19a. Informant's Name/Helationship (7	ype, Print)	1 A	12:10:1	ly or Town, State, 21,	(6)
	s 1 and 2 f Health frem 27 other tr		20a. Method of Disposition	20b. Place of I	Disposition (Name of	Date 200	Location - City or To	T ()ARY) AM
ō	0 0 = =		1 ☐ Burial 2 ∰ Cremation 3 ☐	Removal from State	crematory or other place		. Education Gray of the	om, otalo
altimore	permit. Pege Department o Important: If any Injury or ance.		4 Donation 5 Other (Specify	1- (be)	Aire 12. A. Si	30p P.	1. H TERM	TI HOAYOU
Bal	permit. Pe Departmer Important any Injury		21. Si nature of Funeral Service Licen	в	22. Name and Address of Facility	HUBET-G	Wif Lie	03016 Dich
	00340		Low Low		ot enter the mode of dying, such as cardiac	ive Follow	27-1-151 1.16	ACULA W Approximate
00,	Physician Medical Examiner Physician	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of Due to (or as a consequence	(f):			Onset and Death
8760,	ate b hysic the bu	Ical		d			-	
.O. Box 68	aath certific ettending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 爲JUnknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliv Month	ery Day Year
۵	hat det	h h	Part II. Dthar significant conditions of	ontributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobac	co use contribute to t	he cause of death?
ds,	sign sign d be	d by				1 ☐ Yes	2□No 3□Prol	oably 4 Unknown
Vital Records,	v requ	Completed				24a. Was an	24h Word auto	opsy findings available
ĕ	The law ite has boage 2 st	E C				autopsy	prior to co	impletion of cause of
<u>=</u>	iclan: The l certificate ha ector, page					1 ☐ Yes 2 ☑		2 No
Z.	Physician: this certific	Be	25. Was case referred to medical examiner?	Hospital:	Othor	ath (Check only one)		
70	Phys this eldii	5	1 ∑Yes 2 No 27. Manner of Death	I Impatient 2LAENOUT	patient 3 DOA 4 Indising P	lome 5 Residence		(y)
5	ending i sath. or: After he funer	5	1 □Natural 5 □ Pending	(Month, Day Year) In	jury Work?	Subject	+ < h < + <	FIG
Division of	ttend death stor: A	Certification:	2 ☐ Accident investigation 3 ☑ Suicide 6 ☐ Could not be	J	. 01	28f Location (Stree	t and Number or Run	al Route Number
Ξ	or Atter de Directe	ıtıf	4 Homicide determined	building, etc. (Specify)		City or I im S	le Id Ro	
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	dical Ce	(Check only 2 1 Medical Exam	ysician: To the best of my knowledge, inner: On the basis of examination and	death occurred at the time, date and place for investigation, in my opinion, death occurrence.	and due to the cour	o(s) and manner as	stated. o the cause(s)
	To the I	Med		and manner stated.	29c. License number		Date signed (Month,	
	5 7 ki 7	_	29b. Signature and title of certifier	\cdot Q $\cap \cap$ \cap	O.C.M.E		MARCH 18.	
	100		Malu llu	mica-Tolleha	2			
	10		30. Name and address of person who	completed cause of death (Item 23a)		DE MADVIAN	ກ 212∩1	
			31. Date filed (Month, Day, Year)	32. Registrar's Signature	ENN STREET, BALTIMO	RE, PIAK LLAN	D 71701	
	Sta ₃ Registr		MAR 2. 1	2006 Mayer S	gove			

		•	State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No.
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) Over 18 A pacility Name (If not institution, give street and number) 2. Date of Death Month Day Year 7-20% 1/20 PM 4c. County of Death Carrol 1 4c. County of Death Carrol 1
	Funeral Director		Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Days Hours Min. 9. Birthplace (State or Foreign Country) Usual Residence of Decedent 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Days Hours Min. 9. Birthplace (State or Foreign Country) 9. Birthplace (State or Foreign Country) 9. Birthplace (State or Foreign Country)
	the Maryland 28a-f show	ector	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits, 1 Yes 2 No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "naturel", or Items 23a or 28a-f show or other traumatic svent, the Medical Examiner must be multified at or other traumatic svent, the Medical Examiner must be multified at	Funeral Director	2656 Beck Cysullerd. 2102 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
21215-0036	2 hours afte aturel', or it	ρ	1 Never Married 2 Married 1 Yes 2 No If Yes Give 1 Yes Give 1 Yes 2 No If Yes Give 1 Yes Give 1 No Specify: Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
	filed within 7. Hygiene."nother than "nent, the Medient, the Medient, the Medient, the Medient.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Curpenter 17. Father's Name (First, Middle, Last) (Give kind of work done during most of working life. DO NOT use retired) Self Employed Curpenter 18. Mother's Name (First, Middle, Maiden Sumame)
Maryland	2 should be tand Mental I is marked of aumatic sve	To Be	Christopher Boitzer marquerite Heckie 19a. Informant's Name/ elationship (Type, Print) (WIFE) 19b. Mailing Address (Street and Number or Rural gloute Number, City or Town, State, Zip Code)
-	permit. Pages 1 and 2 Department of Health Important: If item 27 I any injury or other tra ance.		20a. Method of Disposition 1 Burial 2 (DiCremation 3 Removal from State) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or flown, State
Baltimore	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Licensees 22. Name and Address of Facility Peaceful Alternatives Funeral 23. Signature of Funeral Service Licensees 23. Name and Address of Facility Peaceful Alternatives Funeral 23. Name and Crematical Contro
	Physician /Medical		23a. Part1. Enter the disease, of complications in a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causing each line. Interval Between Ornet and District Course (Final disease or condition resulting in death) a. Due to (or as a consequence of):
	Examiner	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):
Box 68	leath certificat attending phy I for use as th	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1
P.O.	res that the designed by the a	by Physic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 9 Unknown 5 Other (specify)
Records,	w requires s been sig	Completed b	1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available
Vital Re	The ate h page	0	autopsy performed? Place of Death (Check only one) Prior to completion of cause of death? Yes 2 No Place of Death (Check only one) Prior to completion of cause of death?
of Vi	> v D	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify)
ion	sing After fune	atlon:	27. Mannet of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury 28b. Time of 28c. Injury at Work? M 1 Yes 2 No 28d. Describe how injury occurred
Division	in Dir	Certification:	3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospitel within 24 hours a To the Funerel completely filled	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
)	To the To the comp	M	29b. Signature and title of certifier \$1000000000000000000000000000000000000
	4		30. Name and address of person who completed cause of death (Mam 23a) Gype, Print) St. Humpstead MD 2074
	Sta Registi		31. Date filed (Month, Day, Year) MAR 2 1 2006 Mar 2 1 2006
DH	MH 17 Rev 1/2	001	MAR 2 1 2006 State of

ORIGINAL

DHMH 17 Rev 1/2001

BAKER

			1 - For State Registrar	State of Maryland / Depa	artment of Health and M tificate of Death	Mental Hygie	2006	08481
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Morn's Bryant			2. Date of Death Month 03	Day Year 17 2006	
	Examir	ner	4a. Facility Name (If not institution, give the Mercy Wedical Co. S. Social Security Number 6. Sec.	ener	Baltimore, M If Under 1 Year If Under 24 Hrs.	8. Date of Birth	8 Baltime	re city
lang.	Funeral Director		217 · 64 · 5293 19 Usual Residence of Decedent	(M 2□ F 49 Yrs.	Months Days Hours Min.	(Manth, Day, Ye	156 Co.	place (State or Foreign intry)
	the Marylan 28a-f ehow	Director	10a, State 10b, County N A	10c. City, Town or Loc Balt	imore			10d. Inside City Limits 1 Arres 2 No
	ath with the 23a or 2	ral Dire	3401 Garriso	n Bowlevard	10f. Zip Code 21215	10g.	Citizen of What Cou	intry?
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiane. Item 27 Is marked other then "naturel", or Items 23a or 28e-f show other traumatic event, the Medical Examinat must be notified at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	1 ☐ Yes 2 🗙 No	Vas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify:	
21215-0036	d within 72 h giane. er then "natu the Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	completed) (Give I	ent's Usual Occupation kind of work done during most of work DO NOT use retired) Labore	ong .	Constru	
Maryland	2 should be filed within and Mental Hygiane. Is marked other than aumatic event, the Me	To Be (17. Father's Name (First, Middle, Last) Willie Bryon		Elizabe	e (First, Middle, Maid W C	ushing to	
	is 1 and 2 sh of Health and item 27 Is m other traum		19a. Informant's Name/Relationship (Ty Juanta Ward	/Sister 7104	g Address (Street and Number or Rur F Bexhill Roa	ol Bart	0. MD 2	1244
Baltimore,	Page ent o nt: If ry or		20a. Method of Disposition 1 Burnal 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	Western	1 Cemetery 03/2	2106 B	altimore	
Bal	permit. Departm Importa eny inju		21. Signature of Funeral Service License	du Co	Name and Address of Facility Physics Stricker Stre 9-1215. Stricker Stre	et Baito. N	10 2122	3
	Physician		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	. , ,	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onsel and Death
	/Medical Examiner							
90,	cate be executed by sician and the burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):				
.O. Box 68760,	The law requires that the death certificate i te has been signed by the attending physi age 2 should be detached for use as the t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year
ords, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions con	tributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacc	co use contribute lo t	1 00
of Vital Records,		Completed				24a. Was an autopsy performed	g prior to co	opsy findings available impletion of cause of
of Vit	Physiclan: This certificatal director, p	To Be	1 Yes 2 No	ospital: 2 ER/Outpatient	3 DOA Cther: 4 Nursing Ho	h <i>(Check only one)</i> me 5 ☐ Residence	6 □Other (Special	fy)
Division o	tending leath. tor: After the funer	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in		
Div	To the Hospital or Attand within 24 hours after death To the Funeral Director: completely filled in by the 1		4 Homicide determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)		Baltmore	MD	
	To the Hospital or within 24 hours afte To the Funerel Dire completely filled in the second second second second second second second second second second second second second second second second second second second se	Medical	one)	icien: To the best of my knowledge, death ler: On the basis of examination and/or inve- and manner stated.	estigation, in my opinion, death occurr	ed at the time, date	and place, and due to	o the cause(s)
	2 3 2 8		29b. Signature and title of certifier	en no	29c. License number P19675	£9d.	3 17 200	Day, Year)
	2		LINDA CHE	mpleted cause of death (Item 23a) (Type, P	P19676 Print) edical Center 30	Ol St. Pau	ul Place J	21202 Batto MD
9.4	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	ul			



			1 - For State Registrar	State of M	laryland / Depa <i>Ce</i>	artment of He <i>rtificate of D</i>			ene 2006	08482
	Physici /Medio		1. Decedent's Name (First, Middle, Las James L. B	^{t)} rown				2. Date of Death Month	Day Year	3. Time of Death
	Examir		4a. Facility Name (If not institution, give Union Memoria			4b. City, Town, or L Baltimon	ocation of Death		4c. County of Death	
	Funeral Director		5. Social Security Number 219-12-9801 6. So	9x 7. A	ge (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yout. 16,	9. Birth 1921 Mar	place (State or Foreign arry) 'yland
	aryland show	3	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	with the Ma s or 28a-f s be maille	Directo	Maryland N/A 10e. Street and Number 1021 W. 38th Street	aat	Baltimor	10f. Zip Code 212	211	10g	. Citizen of What Cou	1XCXYes 2 □ No
980	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland administration of Health and Mental Hyglene. ortant: If item 27 is marked other then "natural", or Items 23e or 28e-1 show injury or other traumatic event, ite Madical Examination until to indifficult a.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Yes 2 V If Yes, Give Year or Dates	No	Was Decedent of Hisp If Yes, specify Cuban,		cify Yes or No- Rican, etc.)	USA 14. Race - Americal Black, White, Specify: White	etc.
21215-0036	d within 72 ho giene. er then "natur ir e Medical.	ompleted	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 1 2		(Give	dent's Usual Occupati kind of work done dur DO NOT use retired) urity Truc	ring most of workir	ng	b. Kind of Business/In rinks Secu	
Maryland	ould be filed Mental Hygid arked other atto event, III	To Be C	17. Father's Name (First, Middle, Last) Lewis Brown			1	8. Mother's Name Irene	(First, Middle, Mai Price	iden Sumame)	
	and 2 should ealth and Men n 27 ia marke er traumatic		19a. Informant's Name/Relationship (7 Jessie E. Brown	урө, Print) Wife	19b. Mailir 10	ng Address <i>(Street and</i> 21 W. 38th	d Number or Rura n Street	Baltimo:	ity or Town, State, Zip re, Maryla	nd 21211
Baltimore,	permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, II a Monee.	1	20a. Method of Disposition 1 XBurial 2 Cremation 3 C 4 Donation 5 Other (Specify 21. Signature Funeral Service Licen)	' Wesley C	hapel Ceme	etery 3/2	1/2006	c. Location - City or To Monkton, M	aryland
Ba	permit. Departn Imports any inju		Dum B	. Hen	3	urgee-Hens 631 Falls	s-Seitz Road, Ba	Funeral l 1timore,	Home, Inc. Maryland	21211
	Pnysician /Medical Examiner	be.	23a. Part1. Enter the disease, or compands, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Myo C Due to (or a	ine. A dial s a consequence of): C NATY s a consequence of):	InFarc Trtery	17			Interval Between Onset and Death A hours I year
8760,	cate be executed physician and the burial-transit	dicai Examine	Sequentially list conditions, if any, leading to intribudate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of):	,				,
.O. Box (death certifi e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of delive Month	ery Day Year
rds, P.	requires tha een signed I nould be det	ρ	Part II. Other significant conditions of	ntributing to death	but not resulting in the u	nderlying cause given	in Part I.	23e. Did tobac 1 ☐ Yes	co use contribute to ti 2 No 3 □ Prot	ne cause of death? ably 4 Dunknown
Vital Records,	The law ate has b page 2 st	Completed	25. Was case referred to medical					24a. Was an autopsy performed	prior to co death?	psy findings available inpletion of cause of 2 No
Ž	\$.s =	To Be	avaminar?	Hospital: 1 ☐ Inpati	ent 2 ER/Outpatien) / Other	 Place of Death Wursing Hom 		e 6 □Other (Specif	()
ion of	ling After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, Da	ury 28b. Time of Injury	28c. Injury at Work?		8d. Describe how i		
Division		Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	jury - At home, farm, str tc. (Specify)	eet, factory, office	2	8f. Location (Stree City or Town, S	t and Number or Rura tate)	l Route Number,
	To the Hospital or within 24 hours after to the Funeral Dir completely filled in	Medical (29a. Certifier (Check only one) 1 ☐ Certifying Phy 2 ☐ Medical Exem	sicien: To the best iner: On the basis of and manner s	of my knowledge, death of examination and/or inv ated.	occurred at the time, restigation, in my opini	date and place, ar ion, death occurre	nd due to the caus d at the time, date	e(s) and manner as s and place, and due to	ated. the cause(s)
	To the within 2. To the I complet	Σ	29b. Signature and Affile of certifier	, MD		29c. License n	umber 3373	l k	Date signed (Month,	Day, Year) 2006
	\Q		30. Name and address of person who co			Print) Paul	Kang,	M.D.		
١	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 1 2		rar's Signature	Carle				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month AARON BLITSTEIN 3:45 P M **ABRAHAM** MARCH 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JEWISH CONVALESCENT CENTER BALTIMORE BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) FEB. 18, 1926 Birthplace (State or Foreign Country) **Funeral** Hours Days 1 M 2 □ F Director 212-36-5996 80 Yrs. **CUBA** Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location r than "natural", or Items 23s or 28s-f show the Medical Exactive must be rediffed at 10d Inside City Limits Funeral Director 1 ☐ Yes 2 🙀 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1345 SUDVALE ROAD 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🗶 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: WHITE δ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 **UPHOLSTERER** FURNITURE REPAIR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be DAVID BLITSTEIN REGINA ဥ DICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sh ment of Health and tent: If Item 27 is n LUCILLE BLITSTEIN / WIFE 1345 SUDVALE ROAD - BALTIMORE, MD 21208 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny injury or 4 ☐ Donation 5 ☐ Other (Specify) HEBREW YOUNG MEN CEM 03/20/2006 WOODLAWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Euneral Service Licensee Jole 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Doset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** GANGRENE OF LEFT FOOT LO WEEKS /Medical Due to (or as a consequence of) Examiner PERLENTERA MASCUM OCCUPSING DISLOYSE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed burial-transit Due to (or as a consequence of): physicien Physician/Medical å. as ettending for use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 | Fetal death 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year ed by the e 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Diabetes Mellitus TYPE TWO Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Criknown COMONARY ANTERY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed BIPOLAR DISORDER 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital : After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 🗷 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending 1 Natural after death.

I Director: Aff
d in by the fur investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Hospitel or filled in To the Hospitel within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier, H45931 wall Gierce March 18, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7220 PANIL ITEIGHTS AVENUE BALTIMONE, MO 21208 Pierce 31. Date filed (Month, Day, Year) Registrar's Signature State MAR 2 1 2006 Registrar

Margaret A. Baynes Margaret A. Baynes Margaret A. Baynes Margaret A. Baynes Margaret A. Baynes About P. Parkellin Name (If not restruction, plue street and number) St. Elizabeth Rehab/Nursing Balttimore St. Elizabeth Rehab/Nursing Balttimore St. Elizabeth Rehab/Nursing Balttimore 10			-	For State Registrar	State	of Mar		artment of H		Mental Hygie	20115	08484
TOTATION OF THE PROPERTY OF TH				1. Decedent's Name (First, Midd	le, Last)						Davi Maria	3. Time of Death
Second Service of Control Second Service of Second Service of Control Second Service of				Margaret A. H	Bavnes					Month	7 200	61:16 a.M
Second Section of Development 100 colors			_			iumber)		4b. City, Town, or	Location of Deeth		4c. County of Dea	
Second Secure Number Secur				St. Elizabeth	Rehab/Nu	rsing		Balt	imore		N/A	
Projection The Street The	Fune	ral			6. Sex			If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bi	thplace (Stete or Foreign
The Sales 10.5 Course 10.5				218-12-2236	1 □ M 2 1 F	84	Yrs.	Moritis Days				
Specify only implicate grader comprehency 10 College (1 fact 5-1) 11 College (1 fact 5-1) 12 College (1 fact 5-1) 13 College (1 fact 5-1) 14 College (1 fact 5-1) 15 College (1 fact 5-1) 16 College (1 fact 5-1) 17 Farance Name (First, Models, Master) 18 Morber's Name (First, Models, Master) 19 College (1 fact 5-1) 19 College (1 fact 5	р.,						0.00.7					
Specify only implicate grader comprehency 10 College (1 fact 5-1) 11 College (1 fact 5-1) 12 College (1 fact 5-1) 13 College (1 fact 5-1) 14 College (1 fact 5-1) 15 College (1 fact 5-1) 16 College (1 fact 5-1) 17 Farance Name (First, Models, Master) 18 Morber's Name (First, Models, Master) 19 College (1 fact 5-1) 19 College (1 fact 5	anyta shov	1	_			1	•					
Specify only implicate grader comprehency 10 College (1 fact 5-1) 11 College (1 fact 5-1) 12 College (1 fact 5-1) 13 College (1 fact 5-1) 14 College (1 fact 5-1) 15 College (1 fact 5-1) 16 College (1 fact 5-1) 17 Farance Name (First, Models, Master) 18 Morber's Name (First, Models, Master) 19 College (1 fact 5-1) 19 College (1 fact 5	8a-f		5		<u> </u>		Balti					7171
Specify only implicate grader comprehency 10 College (1 fact 5-1) 11 College (1 fact 5-1) 12 College (1 fact 5-1) 13 College (1 fact 5-1) 14 College (1 fact 5-1) 15 College (1 fact 5-1) 16 College (1 fact 5-1) 17 Farance Name (First, Models, Master) 18 Morber's Name (First, Models, Master) 19 College (1 fact 5-1) 19 College (1 fact 5	or 2							10f. Zip Code		10g.	Citizen of What C	ountry?
Specify only implicate grader comprehency 10 College (1 fact 5-1) 11 College (1 fact 5-1) 12 College (1 fact 5-1) 13 College (1 fact 5-1) 14 College (1 fact 5-1) 15 College (1 fact 5-1) 16 College (1 fact 5-1) 17 Farance Name (First, Models, Master) 18 Morber's Name (First, Models, Master) 19 College (1 fact 5-1) 19 College (1 fact 5	ath v	1										
Specify only implicate grader comprehency 10 College (1 fact 5-1) 11 College (1 fact 5-1) 12 College (1 fact 5-1) 13 College (1 fact 5-1) 14 College (1 fact 5-1) 15 College (1 fact 5-1) 16 College (1 fact 5-1) 17 Farance Name (First, Models, Master) 18 Morber's Name (First, Models, Master) 19 College (1 fact 5-1) 19 College (1 fact 5	er de temi		nue		Armed	Forces?	er in U.S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		
Specify only implicate grader comprehency 10 College (1 fact 5-1) 11 College (1 fact 5-1) 12 College (1 fact 5-1) 13 College (1 fact 5-1) 14 College (1 fact 5-1) 15 College (1 fact 5-1) 16 College (1 fact 5-1) 17 Farance Name (First, Models, Master) 18 Morber's Name (First, Models, Master) 19 College (1 fact 5-1) 19 College (1 fact 5	S afte				If Yas (Sive		1 □ Yes 2√∑No	Specify:		Specify: T	hita
To Father's Name (Frag. Middle, Latt) 19. Mother's Name (Frag. Middle, Macker Summy) 19. Mother's Name (Frag. Middle, Macker Summ	Pour Fig.		g D			Dates:	150 Dage	tentia I lavat Casa	****	104		
To Father's Name (Frag. Middle, Latt) 19. Mother's Name (Frag. Middle, Macker Summy) 19. Mother's Name (Frag. Middle, Macker Summ	72 u 4	1	je	(Specify only highe	st grade completed		(Give	kind of work done of	during most of work	king	. Kind of Business	vindustry
Clay Ware San A McFaul 190 Malling Address (Sirear and Number or Rural Rouse Number). City or Town, State, Zp Codes) 190 Malling Address (Sirear and Number or Rural Rouse Number). City or Town, State, Zp Codes) 190 Malling Address (Sirear and Number or Rural Rouse Number). City or Town, State, Zp Codes) 190 Malling Address (Sirear and Number or Rural Rouse Number). City or Town, State, Zp Codes) 190 Malling Address (Sirear and Number or Rural Rouse Number). City or Town, State, Zp Codes) 190 Malling Address (Sirear and Number or Rural Rouse Number). City or Town, State, Zp Codes) 190 Malling Address (Sirear and Number or Rural Rouse Number). City or Town, State, Zp Codes) 190 Malling Address (Sirear and Number or Rural Rouse Number). City or Town, State, Zp Codes) 190 Malling Address (Sirear and Number or Rural Rouse Number). City or Town, State, Zp Codes) 200 Method of Deposition 1 Malling Address (Sirear and Number or Rural Rouse Number). City or Town, State, Zp Codes) 21 Signature of Deposition 1 Malling Address (Sirear and Number or Rural Rouse Number). City or Town, State, Zp Codes) 22 Name and Address of Facility. City or Town, State, Zp Codes) 23 Name and Address of Facility. City or Town, State, Zp Codes) 24 Signature and Part of Sirear Address of Facility. City or Town, State, Zp Codes) 25 Name and Address of Facility. City or Town, State, Zp Codes	- 3 S = 8		Ĕ		College	(1-4or 5+)			,		Orana II am a	
Clay W. Ware Rose A. McFaul 19s. Informatrix NamesPalastonahip (Type, Print) 19s. Malling Address (Street and Number or Prais Rose Aumiter, City or Town, State 25 code) Partricial Pohorence/Daughter 435 Droy Street 20s. Mathod of Deposition of Street 20s. Mathod of Deposition of Street and Number of Rose Aumiter, City or Town, State 25 code) 20s. Mathod of Deposition of Street and Number of Rose Aumiter, City or Town, State 25 code) 20s. Mathod of Deposition of Street and Number of Rose Aumiter, City or Town, State 25 code of Street and Number of Rose Aumiter, City or Town, State 25 code of Street and Number of Rose Aumiter, City or Town, State 25 code of Street and Number of Rose Aumiter, City or Town, State 25 code of Street and Number of Rose Aumiter, City or Town, State 25 code of Street and Number of Rose Aumiter, City or Town, State 25 code of Street and Number of Rose Aumiter, City or Town, State 25 code of Street and Number of Rose Aumiter, City or Town, State 25 code of Street and Number of Rose Aumiter, City or Town, State 25 code of Street and Number of Rose Aumiter, City or Town, State 25 code of Street and Number of Rose Aumiter, City or Town, State 25 code of Street and Number of Rose Aumiter, City or Town, State 25 code of Street and Number of Rose Aumiter, City or Town, State 25 code of Street and Number of Rose Aumiter, City or Town, State 25 code of Street and Number of Rose Aumiter, City or Town, State 25 code of Street and Number of Rose Aumiter, City or Town, State 25 code of Street and Number of Rose Aumiter, City or Town, State 25 code of Street and Number of Rose Aumiter, City or Town, State 25 code of Street and Number of Rose Aumiter, City or Town, State 25 code of Street and Number of Rose Aumiter, City or Town, State 25 code of Street and Number of Rose Aumiter, City or Town, State 25 code of Street and Number of Rose Aumiter, City or Town, State 25 code of Street and Number of Rose Aumiter, City or Town, State 25 code of Street and Number of Rose Aumiter, City or Town, Stat	000	1	ပ္ခံ -		Last)		1101	nemaker	18. Mother's Nam	e (First, Middle, Maid		
190. Malino and Disposition (Page Prent) 190. Malino and Disposition (Page Prent) 190. Malino and Disposition (Page Prent) 190. Malino and Disposition (Page Prent) 190. Malino and Disposition (Page Prent) 190. Malino and Disposition (Page Prent) 190. Malino and Disposition (Page Prent) 190. Malino and Disposition (Page Prent) 190. Malino and Disposition (Page Prent) 190. Malino and Disposition (Page Prent) 190. Malino and Disposition (Page Prent) 190. Malino and Disposition (Page Prent) 190. Malino and Disposition (Page Prent) 190. Malino and Disposition (Page Prent) 190. Malino and Disposition (Page Prent) 190. Malino and Disposition (Page Prent) 190. Malino and Disposition (Page Prent) 190. Malino and Disposition (Page Prent) 190. Malino and Disposition (Page Prent) 190. Malino and Page Prent) 190. Malino and Disposition (Page Prent) 190. Mali	E Se la Se Se Se Se Se Se Se Se Se Se Se Se Se			C1 237	T.T	1.7	.					-
Patricia Pohorence/Daughter 20s. Method of Disposition 13 Dual 20 Cemanton 3 Parmoval from State 14 Donation 5 Coher (Speechy) 21 Segnature of Data (Speechy) 22 Segnature of Data (Speechy) 23 Segnature of Data (Speechy) 24 Donation 5 Coher (Speechy) 25 Segnature of Data (Speechy) 26 Physician 27 Segnature of Data (Speechy) 28 Name and Address of Facility 29 Segnature of Data (Speechy) 29 Segnature of Data (Speechy) 20 Segnature of Data (Speechy) 20 Segnature of Data (Speechy) 20 Segnature of Data (Speechy) 20 Segnature of Data (Speechy) 20 Segnature of Data (Speechy) 20 Segnature of Data (Speechy) 20 Segnature of Data (Speechy) 20 Segnature of Data (Speechy) 20 Segnature of Data (Speechy) 20 Segnature of Data (Speechy) 21 Segnature of Data (Speechy) 22 Segnature of Data (Speechy) 23 Segnature of Data (Speechy) 24 Segnature of Data (Speechy) 25 Segnature of Data (Speechy) 26 Segnature of Data (Speechy) 27 Segnature of Data (Speechy) 28 Dual (Or as a consequence of): 29 Dual (Or as a consequence of): 20 Dual (Or as a consequence of): 20 Dual (Or as a consequence of): 20 Dual (Or as a consequence of): 20 Dual (Or as a consequence of): 21 Dual (Or as a consequence of): 22 Segnature of Data (Speechy) 23 Dual (Or as a consequence of): 24 Dual (Or as a consequence of): 25 Dual (Or as a consequence of): 26 Dual (Or as a consequence of): 27 Dual (Or as a consequence of): 28 Dual (Or as a consequence of): 29 Dual (Or as a consequence of): 20 Dual (Or as a consequence of): 20 Dual (Or as a consequence of): 20 Dual (Or as a consequence of): 21 Dual (Or as a consequence of): 22 Dual (Or as a consequence of): 23 Dual (Or as a consequence of): 24 Dual (Or as a consequence of): 25 Dual (Or as a consequence of): 26 Dual (Or as a consequence of): 27 Dual (Or as a consequence of): 28 Dual (Or as a consequence of): 29 Dual (Or as a consequence of): 29 Dual (Or as a consequence of): 20 Dual (Or as a consequence of): 20 Dual (Or as a consequence of): 20 Dual (Or as a consequence of): 21 Dual (Or as a consequence of): 22 Dual (Or as	Should Mould maril	1	_			VV d		na Address (Street a			2.3.0 2.50	
Secretarian Commission Co	Mar od 2 g lith ar 27 ls					htor				76		•
Secretarian Commission Co	ta La Co		1		епсе/ рац	gircer	20b. Place of Dispo	sition (Name of				
Physician Michael 23a Part. First me highest or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate information of cause (Phale State and Physician Physici	0 0								1			
Physician Michael 23a Part. First me highest or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate information of cause (Phale State and Physician Physici	ITIN				· · · · · · · · · · · · · · · · · · ·	}				0/2006	Baltimor	e MD
Physician Medical Examiner Physician (Medical Examiner) Physicia	Department	ouce		N	//		,	Charle	s S. Zeil	ler & Son,	Inc.	
Physician / Medical Examiner Part Department Depar	-			77	the second secon	caused th	e death. Do not ent	6224 E	astern A	zenue Ral	timore	
Due to (or as a consequence of): Due to (or as a consequence of):		3	1	shock, or heart (affure. List	only one caus	each line.		/	-		1	Interval Between
Due to (or as a consequence of): Due to (or as a consequence of):		_		disease or condition	_a. (E	Ft,	plo-va	10416	o ac	Louell		4days
Due to (or as a consequence of): Control			1	rooming in Godany	Due t	o (or as a c	consequence of):					
Due to (or as a consequence of): Due to (or as a consequence of):			-	Sequentially list conditions,	Due t	0 /or 25 2 0	consequence of):	3 3000				
Due to (or as a consequence of): Due to (or as a consequence of):	De isi		- Fine	cause. Enter Underlying Cause (Disease or injury		o (or as a c	consequence on).					
Second Color Col	and and		xau	trial initiated events	c. Due to	o (or as a c	consequence of):					
FFEMALE: 236. Was decedent pregnant in the past 12 months? 1 10 10 10 10 10 10 10	be e buris		<u> </u>			,						
1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 1 Yes 2			200		d							
1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 1 Yes 2	certif certif ding		/Me		23c. If yes, o	utcome of	pregnancy				22d Date of de	D
1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 1 Yes 2	Bath atter		lar	in the past 12 months?	1 Live	birth 2	Fetal death 3					,
1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 1 Yes 2	S e e e		ysic				io di doatii 3	Other (specify)		-		
1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 3 Probably 4 Unkroll 1 Yes 2 No 1 Yes 2	that if details	1		Part II. Other significant conditi	ons contributing to	death but n	not resulting in the ur	nderlying cause give	en in Part I.	23e. Did tobaco	o use contribute to	the cause of death?
24a. Was an autopsy findings avain prior to complete on draws death? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 5 Pending investigation investigation 3 Suicide 4 Homicid			0			a	_	, ,		1 🗀 Yes	2 No 3∏P	robably 4 Dunknown
1 Yes 2 No No No No No No No	req read been shoul	11	ere				-					
1 Yes 2 No No No No No No No	e tay		E .							autopsy	24b. Were a prior to	completion of cause of
Again of Death Natural Suicide Specify Specify Suicide Specify Suicide Specify Suicide Specify Suicide Specify Suicide Specify Suicide Specify Suicide Specify Suicide Suicide Specify Suicide Suicide Specify Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Specify Suicide	ate T										No 1 ☐ Yes	No No
Again of Death Natural Suicide Specify Specify Suicide Specify Suicide Specify Suicide Specify Suicide Specify Suicide Specify Suicide Specify Suicide Specify Suicide Suicide Specify Suicide Suicide Specify Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Specify Suicide	VIII ician certif		מ	examiner?	Hospital:		5,7-20	Oth	1			
1 Matural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28e. Place of Injury At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and didress of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year)	_ & .si.b	. [*	- 1		11			1 3 DOA	Aug Nursing Ho			cify)
Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 29f. Location (Street and Number or Rural Route Number, City or Town, Stete) 29a. Certifier (Check only one) 29c. Certifier (Check only one) 29c. Signature and title of certifier and manner stated. 29b. Signature and title of certifier 29c. Signature and didress of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 29c. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Da			0	1 Natural 5 ☐ Pendir	ig (Mo	onth, Day Y				28d. Describe now in	njury occurred	
29a. Cartiflier (Check only) 29a. Cartiflier	It in the state of		loa		not be		A1 h = = 1 = = 1			004 1		
29a. Cartiflier (Check only) 29a. Cartiflier	or A after Direction by				ined 286. Plac buil	ding, etc. (Specify)	eet, factory, office		City or Town, St	and Number or H ete)	ural Houte Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Person Christel Lane half us)	pital purs ours eral		2	292 Cartifier IN Cartifyin	o Physician, To 4	a boot of o	The leading of the latest the lat					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Person Christel Lane half us)	Hos 24 hc Fun		IICa	(Check only 2 Medical	Examiner: On the	basis of ex	tamination and/or inv	restigation, in my op	ie, date and place, pinion, death occuri	and due to the cause red at the time, date a	e(s) and manner as and place, and due	s stated. e to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Person Christel Lane half us)	o the thin; the		ĕ Z			State State	-	29c. License	number	294 1	Date signed (Mont	h. Dav. Year)
Of Day Flad (Mark Day Var)	F ≯ F 8				/ /(M	201	7740	5 11	100 7	10 2006
Of Day Flad (Mark Day Var)	1-		-	20. Name and address of a	who completed a	upo of de-	h (Itam 02a) (T	Orint)		W.	41.12	1,000
Of Day Flad (Mark Day Var)	9			11 /	who completed ca		U HLG	Elen	Usoil	e lan	1 fall	Jun 2/21
Registrar MAD 2 1 2006 Research	13-15	State		Of Day 61 of Office Day	32.	Resistrar's	0:					
				MAR 9	1 2006	Fo. 2	K A	out				

_			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of H		ental Hygie Reg.		08485
П	Physic	an	Decedent's Name (First, Middle, La	st)		ordes		Date of Death Month,	Day Year	3. Time of Death
	/Medi	cal	(Jeorge 4a. Facility Name (If not institution, give	e street and number)			Location of Death	March	16 2006 4c. County of Death	5152 PM
	Examir	ner		Niew Medica	1 Center	Baltim			Baltimore	
	Funeral Director		5. Social Security Number 6. S	Sex 7. Age	(In yrs. last birthday, 53 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye NOV 18,	9. Birth	nplace (State or Foreign untry) INESSEE
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Maryl -1 ehc	tor	MD N,	'A		Balti	nore			1 XYes 2 ☐ No
	th the or 28s	irec	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cor	untry?
	ath wi	rai	827 S. Grundy S				21224		USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: if Item 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other traumatic event, ir a Medical Expirit or must be invitted at 2006.	by Funeral Director	Never Married 2 Married Widowed 4 Matriced Widowed 4 Matriced	12. Was Decedent E Armed Forces? 1 Tyes 2 X If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 【No	ispanic Origin? (Spe n, Mexican, Puerto I Specity:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	e, etc.
Š	2 hou	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	ation	166	o. Kind of Business/i	nite ndustry
21215-0036	vithin 7 ne. hen °n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5	+) life.	DO NOT use retired	during most of workii)	- C	ommunicat	
	Hygie Hygie ther t		17. Father's Name (First, Middle, Last	4		Engineer	18. Mother's Name	(First, Middle, Mai	echnology	
Maryland	id be lentel ked o ic eve	To Be			Cordes		Clara	Audr		illiams
ary	shou and M mar		19a. Informant's Name/Relationship (ng Address (Street			ity or Town, State, Z	
	and 2 ealth in 27 i		Kathryn A. Cordes	, daughter		E. Randal			e, MD 21:	
lore	ges 1 if itel or oth		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐		1	matory`or other plac	e)		. Location - City or 1	'own, State
Baltimore,	it. Pa rtmen rtant: njury		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lices	• •	Metro Cr MacNabb	ematory,	Inc. 03/1	7/06	Baltimore	, MD
Ba	Department of the partment of		See E	Mar All	riacivation	2. Name and Address	Frederic	ek Road	ociety of Baltimore	MD, Inc. , MD 21228
	Physician		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each lin	e.					Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)		a consequence of):	rijure				
	LXammer	_	Sequentially list conditions,	b. Seps	Consequence off:					Tweet
	uted d ansit	Examiner	Sequentially list conditions, flary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Special	anones Rec	Lori Pri	pritis			1 Week
o Î	e exec en an	Еха	resulting in death) Last	Due to (or as a	consequence of):		2 1			1+ 1/
8760,	cate be executed physicien and ithe burial-transit	dicai		d. End st	rage Alcoho	olic liver -	failure			1 year
.O. Box 6	The law requires that the death certify ate has been signed by the attending page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 1 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delin	very Day Year
Ω,	w requires thet been signed b should be deta	ed by Pt	Part II. Other significant conditions (contributing to death bu	it not resulting in the u	nderlying cause give	en in Part I.	23e. Did tobac	co use contribute to	
of Vital Records,	The law reate has be page 2 sho	Completed						24a. Was an autopsy performed	prior to c death?	topsy findings available ompletion of cause of
Vita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital:		1 04	26. Place of Death	(Check only one)		
5	Phys rthis ral dir	6	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injur			4 Nursing Hon	ne 5 Aesidence 28d. Describe how i	e 6 □Other (Spec	ify)
on	nding fath. r: After e funer	ation	1 Natural 5 Pending 2 Accident investigatio	(Month, Day		Worl	r? Yes 2 □No	Edd. Describe flow (injury occurred	
Division	s after death	Certification:	3 Suicide 6 Could not be determined	e 28e. Place of Inju building, etc	ry - At home, farm, st . (Specify)	reet, factory, office	2	28f. Location (Stree City or Town, S	t and Number or Ruitate)	al Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his comiletely filled in by the funeral director, page	edicai	29a. Certifier 1 ✓ Certifying Ph (Check only one) 2 ☐ Medical Exam	nysician: To the best of niner: On the basis of and manner sta	examination and/or in	h occurred at the tim vestigation, in my of	ne, date and place, a pinion, death occurre	and due to the caus ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
ľ	To 1 To 1	Σ	29b. Signature and title of certifier	ghfill, M. L),	29c. License	5 - 000	29d.	Date signed (Month arch 16, 200 Highfill	, Day, Year)
	15		30. Name and address of person who	P 14		Print)		TM	High Cill	
	Sta	to	31. Date filed (Month, Day, Year)	antical	r's Signature	A.L. A. 209		Jettrey	migultill	
	Registi	20.0	MAR 2 1 20	06 Here	. It has	ules				
DH	MH 17 Rev 1/2	001			1					

			State of Many State	yland / Depa	artment of Health and M	-	_	08486
				Cer	tificate of Death		g. No.	
	Physic	ian	1. Decedent's Name (First, Middle, Last)			2. Date of Deat Month	Day Year	3. Time of Death
	/Medi		Thomas Francis Conn 4a. Facility Name (If not institution, give street and number)	er	AL Cit. Township (Co.)	March	20 2000	
	Examir	ner		1 0	4b. City, Town, or Location of Death		4c. County of Dea	
	Comment		Baltimore Washington Medic 5. Social Security Number 6. Sex 7. Age (h	al Center	Glen Burnie If Under 1 Year If Under 24 Hrs.	8 Date of Birth	Anne Aru	
	Funeral Director		212-22-2211 1\(\overline{x}\) ¹ \(\overline{x}\) ¹ \(\overline{x}\) ² \(\overline{x}\)	86 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, MAR 27	Year) 3. 6. 7. 7. 1919 Ma	thplace (State or Foreign ountry) ryland
			Usual Residence of Decedent			11/11/12/	1/1/ 1/10	Lyland
	inylar ihow	_	10a. State 10b. County 10	Dc. City, Town or Lo-	cation			10d. Inside City Limits
1	Ba-fs	cto	Maryland Anne Arundel		Severn			1 ☐ Yes 2 ☐ No
	or 2	Director	10e. Street and Number		10f. Zip Code	10	g. Citizen of What C	ountry?
1	i. K. I.3-UU.30 within 72 hours after death with the Maryland ene. then "natural", or itams 23a or 28a-1 show it Medical Exertile or rost be nutilied at		8045 New Cut Road		21144		US	
NNE	er de Itam	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ⚠ No	ir in U.S. 13. V	Vas Decedent of Hispanic Origin? (Sp i Yes, specify Cuban, Mexican, Puerto	acify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
7	rs aff	by F	3 XWidowed 4 □ Divorced If Yes, Give Year or Dates:	1	☐ Yes 2 X No Specify:		Specify:	TTILL L
NNO	2 hou		15. Decedent's Education	16a. Deced	lent's Usual Occupation		16b. Kind of Business	White
2	hin 7:	pie	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done during most of work OO NOT use retired)	ing		····-,
č	d will	Completed	8	Mec	hanic		Chemica1	Industry
3	be filed stal Hygind of other avent, L	Be (17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, M		,
50 5	iaryiana z Should be filed and Mental Hygi is markad other sumatic avant, I	2	Francis Crandell			e F. Cor		
F.	20 S B B B B B B B B B B B B B B B B B B		19a. Informant's Name/Relationship (Type, Print)		g Address (Street and Number or Rura			
~	2 2 2 2		Richard A. Conner/Son	8049	Veterans Highway	Lot #2	, Millers	ville, MD
£	8 7 2 2		i — bunar 2 M Cremation 3 — Removaritom State		natory or other place)		loc. Location - City or	Town, State
\ <u></u>	LITT t. Pa rtmer rtant rjury			Metro Cre	matory, Inc. 3/21	/06	Baltimore	, MD
7 6	Dallillid permit. Pag Department Important: h any injury o		21. Signature of Funeral Service Literature	22	Name and Address of Facility Cr	emation	Society o	f MD, Inc.
			Fdward A Gregorchik		99 Frederick Road			LZZ8 Approximate
			23a. Part1. Enter the disease of complications that caused the shock, or heart failure. List only one cause on each line.	1	in the mode of dying, sum as cardiac o	n respiratory arre	St,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	two	reart tarles	re		
	Examiner		Due to (or is a co	onsequence or):	to a	00.0		
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	onsequence of):	yeing our			
v	uted d ansit	Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events		(
	be executed sician and burial-transit		resulting in death) Last Due to (or as a co	onsequence of):				
052	w > 0	Icai	d					
9 20	death certificate attending phy	Med	IF FEMALE:				1	
Č	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	Fetal death 3	Ectopic pregnancy		23d. Date of de Month	livery Day Year
-	the a	/sic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time 9 ☐ Unknown 9 ☐ Unknown	e of death 5	Other (specify)		WORKE	Day 16a1
	res that the designed by the a	by Physician/Med	Part II. Other significant conditions contributing to death but no	ot resulting in the un	deriving cause given in Part I	23e. Did tob	acco use contribute to	the cause of death?
Olivicion of Wital Docords	To the Hospital or Attending Physicien: The law requires that the death certifical within 24 hours after death. Within 24 hours after death. To the Funarel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the			-				obably 4 Unknown
Ş	aw requir	Completed				24a. Was an		utopsy findings available
à	The lav	E O				autopsy perform	ed? death?	completion of cause of : 2□ No
	intifica	ВеС	25. Was case referred to medical		26. Place of Death		1	
>	hysic hysic hysic l dire	To	examiner? 1 Yes 21 No Hospital: Inpatient	2 ER/Outpatient	3 DOA Other: 4 Nursing Hor	ne 5 🗆 Resider	nce 6 Other (Spe	cify)
2	ding Physicien: After this certific funeral director.	on:	27. Manner of Death 1 Deatural 5 ☐ Pending (Month, Day Ye	28b. Time of Injury	28c. Injury at Work?	28d. Describe how	v injury occurred	
- 0	tendi leath. for: A	cati	2 Accident investigation		M 1 Yes 2 No			
	or At after of Dirac	Certification:	4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide	At home, farm, stre Specify)	et, factory, office	28t. Location (Str. City or Town,	eet and Number or Ru State)	ural Route Number,
_	spital sours narel	ai C	29a. Certifier 1 Certifying Physician: To the best of m	y knowledge, death	occurred at the time, date and place, a	and due to the car	use(s) and manner as	stated.
	To the Hospital or Attanwithin 24 hours after deat To the Funarel Diractor: completely filled in by the	Medical	(Check only one) 2 Medical Examiner: On the basis of examiner stated.	amination and/or inv	estigation, in my opinion, death occurre	ed at the time, da	te and place, and due	to the cause(s)
	To 1 To 1	Σ	29b. Signature and title of certifier		29c. License number		d. Date signed (Mont	
			they me		1043977		larch 20,	2006
	2		30. Name and addiss of person who completed cause of death	(Item 23a) (Type F	Stre, aly Br	mai - M	W- 210	L
1	Sta	te	B1. Date filed (Month, Day Year) NAR 2 1 2006	Signature	- 1 Planahe Ilm	1	VI) A IU	b[·
	Registr	ar	MAR 2 1 2008	JB A	recks)			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month March 20, 2005 LaVerne Rache1 Cline 6:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Baltimore Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | APR 3, 1921 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F 233-05-9551 84 Yrs. West Virginia Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 68 Crystal Court 21014 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give → Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. other traumatic syent, the Madical Examiner 1 □ Never Married 2 □ Married ō Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. 3 XWidowed 4 ☐ Divorced White "natural" Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fit and Mental H John ဥ Harrison Fleming Emma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn C. Carr, daughter 1730 Eden Mill Road Pylesville, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 5= 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ò 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 03/20/06 Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb | 22. Name and Address of Facility Cremation Society of MD, Inc. Seiz E. Max All 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** disease or condition resulting in death) colon Metasbote cancel Yravs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed ettending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 Probably 4 □Unknown Completed 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an this certificate has al director, page 2 autopsy performed? Yes 2 10/100 1 Yes After this certification funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Nor Pice 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 ☐ Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident I Director: / 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ò within 24 hours e To the Funeral C Certifying Physician: To the heat of my knowledge ideath occurred at the time, date and place, and due to the cauca(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 58303 2006 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles ST BOUTMORE MO 2124 31. Date filed (Month, Day, Year) 6601 an 32 Registrar's Signature State MAR 2 1 2006 Registrar

Mareh 20, 2006 dots

AVERNE

			1 - For State Registrar	State of Mai	rylan	-	artmen			ind Me		iene	06	08488
	Db		1. Decedent's Name (First, Middle, Las		0					2	Date of Deat	Daly	Year	3. Time of Death
	Physici Medio/		Jose	SPH C	120	220				1	March		2006	17.35 p.M
)	Examir		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location of	f Death			ty of Death	
			Northwest Hospi		"				Stown			l E	Baltin	
	uneral irector		5. Social Security Number 6. S 218–14–1339	ex 7. Age OXM 2□F	80 (In yrs. 1	last birthday Yrs.	Months	Days	Hours		Date of Sirth Month, Day, DEC 17,	1925	9. Birth	place (State or Foreign ntry) ary1and
p	>		Usual Residence of Decedent 10a. State 10b. County		10a Cib	, Town or L	continu							104 (
laryla	a po	5			100. 011)	, rown or L		1 44						10d. Inside City Limits 1 ☐ Yes 2 🕅 No
the A	28a-1	Funeral Director	MD Balt:	imore			10f. Zip		stown	<u> </u>	10	g. Citizen o	(What Cou	
with	3e or	<u>=</u>	3708 Marriottsv	illo Pood			101. 210	0000	2113	2	, ,			illy t
death	ms 2	era	11. Marital Status	12. Was Decedent Ev	er in U.	S. 13.	Was Deced	lent of Hi			fy Yes or No- can, etc.)	14. Ra	USA ace - Ameri	
after	e H	Ē	1 ☐ Never Married 2 X Married	Armed Forces? 1 Yes 2 □ No If Yes, Give						, Puerto Ri	can, etc.)		ack, White,	etc.
Sours	E. E.	d by	3 Widowed 4 Divorced	Year or Dates:	WW	II	1 ☐ Yes	2 X No	Specify:			Spec	Wh:	ite
2 4 2 L	net.	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)		(Giv	edent's Usua e kind of wo	rk done d	lurina most	of working	, 1	6b. Kind of	Business/In	dustry
Mithigh M	Line Man	mp	Elementary/Secondary (0-12)	Cotlege (1-4or 5+))	life.	DO NOT us							
filed v	D. E.	e Co	17. Father's Name (First, Middle, Last)				Carp	ente		r's Name (First, Middle, N		truct	10n
d be fill	o p o	To Be		C. Cross						He1e			onner	
at y fattic X IX I 3-0030 should be filed within 72 hours after death with the Maryland nd Manial Pyclene.	Tan.	-	19a. Informant's Name/Relationship (1	Type, Print)		19b. Mail	ing Address	(Street a	and Number		Route Number,			
nd 2	27 is r tra		Louise L. Cross,	wife		3708	Marr	iott	svill	e Roa	ad Rano	dallst	own.	MD 21133
S - G	item othe		20a. Method of Disposition		20b. Pl	lace of Disp emetery, cre	osition (Nan	ne of		Dat		Oc. Location		
Page	int: if		1 ☐ Burial 2 XX Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			ro Cr				03/19	/06	Balt:	imore	, MD
Daltillo Dermit. Pages Department of	importent: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once.		21. Signature of Funeral Service Licen	‱ George M	lacNa	abb 2	2. Name an	d Addres	s of Facility	Cre	mation			MD, Inc.
8.0	트뉴의		Xen Elgo	AH					reder				re, M	D 21228
/M Exa	sician edical iminer	ner	23a. Part1. Enter the disease, or comy shock, or heart failure. List only temperature that the cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhitated events	a	consequ	S Expression (S):	SIS		g, Such as C	Sardiac Or 1	espiratory arre	51,		Approximate triterial Between Onset and Death
Physician: The law requires that the death certificate be executed	g physicien and as the burial-transit	ledicai Examiner	resulting in death) Last	cDue to (or as a d	consequ	ience of):								
the death cer	been signed by the attending pr should be detached for use as t	Physician/Med	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal	death 3	⊒Ectopic pr ⊒ Other (sp						ate of delivers	ery Day Year
s that	a det	by Pi	Part II. Other significant conditions of	ontributing to death but	not resu	ılting in the u	inderlying c	ause give	n in Part I.		23e. Did tob	acco use co	ntribute to t	he cause of death?
daire	en sig	ed	CHRONIC KIDN	by DISEAS	SE,		E2 E5	3020 V	MSCU	VAR	1 🗌 Ye	2 DANO	3 Prot	pably 4 Unknown
e lawre	2 5	Completed	DISEASE HY	PERTENS	ION						24a. Was an autopsy perform		. Were auto prior to co death?	ppsy findings available impletion of cause of
ם ה ה	icete r, pag										1□ Yes 2	No	1 Yes	2 No
Biciar	recto	Be.	25. Was case referred to medical examiner?	Hospitat:				Othe	-		Check only one			-
5 £	i E la	2	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day)		ER/Outpatie 28b. Time d		Bc. Injury Work	4 🗀 (401)		5 ☐ Resider			(y)
e die	: Afte	at lo	1 ☑Naturat 5 ☐ Pending 2 ☐ Accident investigation		(ear)	Injury	м		? ∕es 2 🗌 N	lo		. ,		
or Atte	Director: After this certificate ha	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of tnjury building, etc.	r - At hor (Specify	me, farm, st	reet, factory	, office		28	f. Location (Str. City or Town,	eet and Num State)	nber or Rura	al Route Number,
To the Hospital or Attending within 24 hours effer death.	To the Funeral completely filled	edicai C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of iner: On the basis of e and manner state	xaminati	wiedge, dear ion and/or in	th occurred investigation,	at the tim- in my op	e, date and inion, death	place, and	d due to the ca at the time, da	use(s) and n te and place	nanner as s , and due to	tated. o the cause(s)
		¥	29b. Signature and title of certifier	anagens	^	10		License) 5	428	88		d. Date sign	di 18	34 2006
r,	3×1		30. Name and address of person who of Ram & Wamy	I Kan	gar	uga	Print	Nor	thive	ert	Hospit	al (iente	ર્
H	Sta Registr		31. Date filed (Month, Day, Year)	32 degistrar	s signat	Z A	Markey !							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 18, 2006 James Cochran Harvey March 1:28 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Havre de Grace Hospital <u>Harford</u> 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
March 10, **Funeral** Birthplace (State or Foreign Country) 1**X** M 2□ F Months Days Hours 220-50-3281 Director 55 1951 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f shov other traumatic event, the Madical Examiner must be notified at Completed by Funeral Director 1 ☐ Yes 2 No Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 556 Warren Street, Apt. 8 21078 2 should be filed within 72 hours after death and Mental Hygiene. USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 XWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mason Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Garvey Cochran Gertie permit. Pages 1 and 2
Department of Heelth an important: if item 27 is meny injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James D. Cochran, son 83 Long Beach Road Charlestown, MD 21914 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 03/20/06 Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. Leon 299 Frederick Road Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine cate has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit 68760 Physician/Medical Box (23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 □Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Completed 1 ☐ Yes 2 ☐ No 3 Dobably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No After this certificate funeral director, pag Vital 25. Was case referred to medical 26. Place of Death Check only one examiner?
1 Yes 2 No Hospital Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 2 ER/Outpatient 3 DOA ð 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Medical Certification; Division Natural 5 Pending investigation within 24 hours after death.

To the Funerei Director: Af 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Hospitel or Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cau P 31. Date filed (Month, Day, Year) State MAR 2 1 2006 Registrar

			1 - For State Registrar	State of Marylar	-	artment of F		-	giene Reg. No.	6	08490
	Physici /Medic		1. Decedent's Name (First, Middle, Last, ELMER NIC	CHOLSON	Ct	HAMBE	ERS	2. Date of Dea Month MARCH	ath Day	Year OO6	3. Time of Death
	Examin		4a. Facility Name (If not institution, give HARBOR HOS				Location of Death	h	4c. County		
	Funeral Director		5. Social Security Number 6. Sec 217 34 4903	7. Age (In yrs. 3M 2□F 67	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Aug. 28	h Year) 3, 1938		olace (State or Foreign ntry) yland
	•how	5	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Ary		ty, Town or Lo						0d. Inside City Limits 1 ☐ Yes 2 ▼ No
	h with the N 23a or 28a-1	ai Director	Maryland Anne Art 10e. Street and Number 319 W. 6th Aven		Baltimo	ore 10f. Zip Code 212	225		10g. Citizen of V	Vhat Coun	
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heath and Mental trygiene. Important: if Item 27 ie marked other than "netural", or iteme 23s or 28s-1 show eny injury or other traumatic event, the Medical Esartinar must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Blac	- Americ k, White,	
21215-0036	vithin 72 hou ne. han "neture Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 1 2 t h	cation	(Give	dent's Usual Occup kind of work done OO NOT use retired t Medal N	during most of wor ()	king	16b. Kind of Bu		dustry
	itd be filed v lentat Hygie ked other t itc event, th	To Be Co	17. Father's Name (First, Middle, Last)	Chambers	Blice	ic ricuar i	18. Mother's Nan	ne (First, Middle, lys Phili	Maiden Sumam		FTOU
, Maryland	and 2 shouealth and N may 1 e mai		19a. Informant's Name/Relationship (Ty Carolyn Chambers	/ wife	319 W	ng Address (Street		Baltimon			
Baltimore,	t. Pages 1 trent of H rtent: if iter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, crei Ly Cros	sition (Name of natory or other places Cemete	rv3/18		20c. Location · Baltimo:	re, M	Maryland
Ba	permi Depa Impo eny ii		21. Signalur Funcial Service License 23a. Part 1. Enler the disease, or complications and situations and situations and situations are situations.	Cations that caused the dear	e 4	2. Name and Address 2001 Ritch er the mode of dvio	ie Highw	once Fun ay Balt	imore.		and 21225
	Physician /Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	PNEUM Due to (or as a consec	ONIF		5			T	Interval Between Onset and Death NO WEEKS
	Examiner	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	SEPSIS Due to (or as a conseq	uerice of):					• •	
8760, 🛠	icate be executed physicien and the burial-transit	dical Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):						
P.O. Box 68	Attending Physician: The law requires that the death certifica r death. r death. ector: After this certificete has been signed by the attending ph by the funeral director, page 2 should be detached for use as th	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregni 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	ldeath 3	Ectopic pregnancy Other (specify)			23d. Date Mor	e of delive	ory Day Year
	quires that n signed b uld be deta	ed by Pr	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause give	en in Part I.			bute to th	g cause of death?
l Reco	The law requirele has been si page 2 should	Somplet	2) ASBESTOS	15	-			24a. Was a autop: perfor	med? p	eath?	osy findings available npletion of cause of
of Vita	Physician: this certific al director.	To Be	25. Was case referred to medical examiner? 1 Yes Wo H	ospital: Inpatient 2 28a. Dale of Injury	ER/Outpatien		9r: 4 ☐ Nursing H	th Check only or	ence 6 Othe	ır (Specify	
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours efter death. To the Funeral Director: After this certificete has completely filled in by the funeral director. page 2	Certification:	VMatural 5 Pending investigation 3 Suicide 6 Could not be determined	(Month, Day Year) 28e. Place of Injury - At he building, etc. (Specif			res 2 □No		ow injury occurre treet and Numbern, State)		Route Number,
_	To the Hospital or Attenwithin 24 hours effer deatl To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier Certifying Physical Concept (Check only one)	ician: To the best of my knoter: On the basis of examina and manner stated.	wiedge, death tion and/or inv	occurred at the time vestigation, in my op	e, date and place, pinion, death occur	, and due to the c rred at the time, o	ause(s) and mar date and place, a	nner as sta	ated. the cause(s)
ì	To the Comp		29b. Signature and title of certifier Ramath	p MD			500	0 1		- i4	- 2006
	4		30. Name and address of person who co DR MAMATHA PRAI	mpleted cause of death (Item 3+1+1 KAR, 30	п 23а) (Туре, О1, S:	Print) HANOVE	R STRE	ZET, BA	LTIMO	RE, I	MARYLAND 1225
	Sta Registr	te	MAR 2 1 200	327Registrar's Signa	ture	reles		_			

DHMH 17 Rev 1/2001

Christopher X Cobb Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06-01667 CTState of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Christopher X. Cobb /Medical March 07 2006 7:49 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8605 Old Branch Avenue Clinton Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days tXDM 2□F 14 Months Hours Director Yrs. 213-35**-**3527 01-30-1992 Washington DC Usual Residence of Decedent 10a. State 10b. County **WOUP** 10c. City, Town or Location treumatic event, the Madical Examiner must be notified at 10d. Inside City Limits MD Director Prince George Clinton 1 ☐ Yes 2 📉 🛪 o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 8605 Old Branch Av 20735 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. within 72 hours after 1 Yes 2X No If Yes, Give Year or Dates: 1√Never Married 2 Married Baltimore, Maryland 21215-0036 5 Completed by 1 ☐ Yes 2000No Specify. Specify: Black 3 Widowed 4 Divorced "nature!" 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) Not Applicable Not Applicable Health and Mental Hygiem 27 is marked other 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) 8 Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
r 805 Brightseat Rd. Landover, MD 20785 permit. Pages 1 and 2 is Department of Health an Important: if item 27 ie eny injury or other treu once. Cecilia A. Martin/social worker 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 € Cremation 3 ☐ Removal from State Chesapeaker Crematory 03-21-2006 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Se 22. Name and Address of Facility
Rapp Funeral & Cremation Service Rapp Funeral & Cremation S 933 Gist Av Silver Spring Shock, or heart failure. List only one cause on each line. 933 Gist Av Silver Spring MD 20910 Approximate Interval Between Onset and Death nmediate Cause (Final Complications Physician of Head Ing disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of). The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physicien the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy 4☐Pregnant at time of death Month Day 5 Other (specify) Year 9 Unknown 9 Unknown à s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part L ۾ 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of d-ath?

1 ✓ Yes 2 □ No certificate has 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Certification: To 1XYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Subject 28a. Date of Injury (Month, Day Year) 28b. Time of Injury After 1 Natural 5 Pending 24/1992 2 Accident investigation assaulted as infant UNKNOWM 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 7401 New Hampshive

To the Hospital or Attending Physicien: i Director: / within 24 hours To the Funerel

> State Registrar

Medical

4 Homicide

29b. Signature and title of certifier

MAR 21

29a. Certifier

31. Date filed (Month, Day, Year) 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

111 Penn Street Baltimore, Maryland 21201

Avenue #600 Hyattsville MD

March 8, 2006

29d. Date signed (Month, Day, Year)

At nome

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

and manner stated.

29c. License number

OCME

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month **Physician** Year Kober ampbell 12-20 PIM March 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner tospital Baltimore If Under 24 Hrs. 8. Date of Birth Hours Min. Month, Dey 6. Sex 1 M 2 F 5. Social Security Number 7. Age (In yrs, lest birthday) If Under 1 Year **Funeral** 240-16-3323 Usual Residence of Decedent Months Days Director permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is merked other than "netural", or items 23e or 28a4 show any injury or other traumetic event, the Medical Examinat must be notified at ence. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits NIA Baltimore Yes 2□ No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3939 21215 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ≥ Yes 2 □ No W Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□Yes 2DNo Specify: þ Specify: Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Glass Co. MOUD MAKER 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 oung a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) renda Flowerton RD. Balto MO 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Garrison cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Forest 4 Donation ♠ □ Other (Specify) Rame and Address of Fecility meral Service Licenses rease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, unequality one cause on each line. Balto 23a. Part1 Approximete Interval Between Onset end Death **Physician** Cardio Vascular disease /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner 10 mucha or Attending Physicien: The law requires that the death certificete be executed ete hes been signed by the ettending physician end page 2 should be detached for use as the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the ceuse of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? certificate 1 🗆 Yes 2 12 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 🛱 ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Yes 2 No After this 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation death. To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A 2 Accident 1 🗆 Yes 2 🗆 No filled in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 151 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Magem

Registrar

State

motor

MAR 2

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

DHMH 17 Rev 1/2001

5:05

2006

18,

ROBIN CROWE

				1 - For State Registrar	State of N	Marylar			nt of H				gien	2000	0849	1
		Physic	an	Decedent's Name (First, Middle, Last) DUVITES MA								2. Date of De. Month	ath 18	y Yea	3. Time of Do	
	1	/Medi Examir	cal	M. PHYLLIS MA 4a. Facility Name (If not institution, give s GILCHRIST					, Town, or			MARCH		2006 County of De BALT	ath	M
		Funeral Director				Nge (In yrs. 87	last birthday) Yrs.	If Undo Months	or 1 Year Days	If Unde Hours	Min.	8. Date of Birt Month, Da SEPT	h Y Year	9. B	irthplace <i>(Stat</i> e or F Country) PA	oreign
		the Maryland r28a-f ehow notified at	tor	Usual Residence of Decedent 10a. State 10b. County MD			ity, Town or Lo								10d. Inside City	
4		death with the ma 23a or 28a r must be not	Funeral Director	10e. Street and Number 3601 GREENWAY				10f. Z	ip Code 2121	18			10g. Ci	itizen of What (Country?	
3:44am	900	72 hours after des natural', or Itema dical Examinar m	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Moriowed 4 □ Divorced	I2. Was Deceden Armed Forces 1 ☐ Yes 2 If Yes, Give Year or Dates	;?] No		Was Deco If Yes, sp 1 Yes		ispanic Or an, Mexica Specify		ecify Yes or No- Rican, etc.)		14. Race - An Black, Wh Specify: W		
v ,	1215-0	c * a	mpletec	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2	cation completed) College (1-4or	r 5+)		kind of w DO NOT	ual Decupa ork done d use retired	during mo: f)	st of workii	ng		Cind of Busines	,	-
.0	Baltimore, Maryland 21215-0036	pemait. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other freumatic event, ITEM ADE.	To Be Completed	17. Father's Name (First, Middle, Last) JOSIAH JACOB MA	RKLE					18. Moth		(First, Middle, MILDF	Maider	Sumame)		
3/18/06	, Mary	end 2 should ealth and Men n 27 is marke ier treumatic		19a. Informant's Name/Relationship (<i>Typ</i>	nephe	W	19b. Mailii 201	ng Addres	s (Street a	and Numb	er or Rura ARDE	NS BAI	r, City (or Town, State,	Zip Code) ID 21210	
3/1	timore	Pages 1 tment of H tant: If ite		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)		! 0	Place of Dispo cemetery, crei RUID	matory or RIDG	other place E		3/22		PI		LE, MD	
	Ba	Depart Impor		21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complice the service of the service of the service service of th	NACO			16	924	YOR	K RD	RY W. MONK	OT		& SONS 21111	co.
•	8760,	that the death certificate be executed Ex Additional the attending physicien and detached for use as the burial-transit detached for use as the burial-transit.	dical Examiner	shock, or heart failure. List only on the timediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e cause on each	s a consequence of a co	ye Can juence of): Line income juence of):					respiratory an	(63),		Approximate Interval Between Onset and Dea	en ath
S	.O. Box 6	that the death certifica ed by the attending ph detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	dc. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 🗌 Feta	I death 3	Ectopic p						23d. Date of de Month	l elivery Day Yea	r
Kylli.	ords, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions conf	ributing to death	but not res	ulting in the u	nderlying	cause give	en in Part I	l.		bacco i		to the cause of deat	
9	Vital Records,	The law ete has b page 2 sh	e Completed	25. Was case referred to medical									med? 2001 No	prior to death?		ilable e of
ait		Physicien: this certific ral director,	To Be	examiner?	ospital:	ient 2 🗆	ER/Outpatien	t 3 🗆 Di	OA Othe			Check only or	-	6 Dinther (Sn	min Hear	
J	Division of	Attending Ph or death. ector: After th by the funeral	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, Da	ury ay Year)	28b. Time of Injury	M	28c. Injury Work 1 🗌 Y		2	8d. Describe h			ecify) Neisfii C	<u>C</u>
	DÌVÌ	호 # 급 드		3 Suicide 6 Could not be determined	28e. Place of In building, e	tc. (Specif	y) 					City or Town	n, State)	lural Route Number	
		To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physical Examin	er: On the basis of and manner st	ot examina	wiedge, death tion and/or inv	estigation	i, in my op	inion, dea	nd place, as	d at the time, d	ate and	d place, and du	e to the cause(s)	
		7 3 5 0		29b. Signature and title of certifier	and	me)		C. License		99	2		te signed (Mon		
		10		30. Name and address of person who con Jason Black,	66011	loin	2 Char		57	70	- دران کارنام	ng	2	1204		
		Sta Registra	re.	31. Date filed (Month, Day, Year) MAR 2. 1 200	32 Regist	rars Signa	enur	action .				•		(

		amend unpend	Ifen#1,23a,27,28 State of Marylan	a-f.peri d/Dep	Æ,g853,3/2 artment of F	2/06 TT Tealth and	Mental Hygie	ne	
		1 - State Registrar			rtificate of		Reg.	12 12 13 14	
Physic	ian	1. Decedent's Name (First, Middle, Last,					Date of Death Month	Day Year	3. Time of Death
/Med	ical		enoweth III				March	14, 2006	
Exami	ner	4a. Facility Name (If not institution, give	,			or Location of Deat mbia	th	4c. County of Dear	th
		Howard County Gene 5. Social Security Number 6. Sec		last hirthday)			8. Date of Birth	Howard	tholace (State or Foreign
Funeral Director			M 2□F 37	Yrs.	Months Days	Hours Min.	(Month, Day, Ye		thplace (State or Foreign ountry)
ס		Usual Residence of Decedent					April 18	, 1900	Maryland
how det	-	10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
8a-f	octo	Maryland Baltimor	e Woo	odstoc					1 Yes 2 No
within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f ehow he Modical Examiter must be notified at	Funeral Directo	10e. Street and Number 2936 Hernwood Ro	- 1		10f. Zip Code			. Citizen of What Co	
eath	eral		a.d. 12. Was Decedent Ever in U.	S 13	Was Decedent of H		Unit	ed State:	s of America
r ften	틢	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐XNo		Was Decedent of H If Yes, specify Cub	an, Mexican, Puer	to Rican, etc.)	Black, Whit	
ol', o	₽	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 💥 □ No	Specify:		Specify: W	hite
72 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece	dent's Usual Occup	nation during most of wo	rkina 16t	. Kind of Business	/Industry
nithin ne. hen.	I de	Elementary/Secondary (0-12)	College (1-4or 5+)	`life.	DO NOT use retire	d)			
iled v Hygie ther ti		12 17. Father's Name (First, Middle, Last)	0	Car	penter	19 Mothor's Na	me (First, Middle, Mai	Construct:	ion
ould be file Mental Hy arked oth	Be	George B. Chenowe	ath Ir				· ·	den Sumame)	
shoute mark mark	2	19a. Informant's Name/Relationship (Ty		19b. Maifi	na Address (Street		. Calp ural Route Number, C	itv or Town. State. 2	Zin Code)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show pinjury or other traumatic event, the Medical Examiner must be notified at once.		George B. Chenower	h (Father)				oodstock,	-	
s 1 a of Hear team	-	20a. Method of Disposition	20b. P		sition (Name of matory or other plac			. Location - City or	
permit. Pages Department of mportant: if it iny injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	IOITIOVALITOTTI STATO		ematory I	1	8/06 Bal	timore. N	m 21229
permit. Departn Imports eny inju	П	21. Signature of Funeral Service Licens						Funeral	Directors,In
8978		Twendelse 1.	Hemining	87	28 Liber	ty Road,	Randallst	own, Mary	land 21133
		25a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ications that caused the death ne cause on each line.	. Do not en	er the mode of dyin	ng, such as cardia	c or respiratory arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Alcohol and nai	rcotic i	intoxicatio	n			Onset and Death
/Medical Examiner	н	resulting in death)	Due to (or as a consequ		J				
		Sequentially list conditions,	Due to for as a soneage	cons. A					
nted Insit	uln u	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury	220 to (2. do 2 00.1004)	201.00 01).					
be executed ician and burial-transit	cal Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):					
ate be executed hysician and the burial-transit	cal		i.						
certifica Iding ph	Aed	(E EFMALC)							
th ce tendii	an/	230. Was decedent pregnant	3c. If yes, outcome of pregnal 1 Live birth 2 Fetaf		Ectopic pregnancy	y		23d. Date of del	•
e death the atten	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐Unknown		Other (specify)			Month	Day Year
w requires that the death certifica been signed by the attending ph should be detached for use as It	by Physician/Med	Part II. Other significant conditions col	ntributing to death but not resu	ulting in the o	nderhing cause an	on in Part I	23e Did tohac	co use contribute to	the cause of death?
signe d be		,			indonying oddos giv	on arr arr.	1 ☐ Yes		1.
faw requas been 2 shoul	Completed				-		24a. Was an	24h Woro au	itopsy findings available
The law ate has b page 2 st	E G						autopsy performed	re digital?	completion of cause of
En: T	0	25. Was case referred to medical				26 Place of De.	1)∑ Yes 2 □ ath Check only one	No 11 Yes	2□ No
Physician: The law this certificate has b ral director, page 2 s	To B	examiner? 1X Yes 2 □ No	lospitaf: 1 ☐ Inpatient 2 🛣 I	ER/Outpatier	nt 3□ DOA Oth		lome 5 ☐ Residence	e 6 □Other (Spe	cify)
ng Pt fter th neral		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injur Wor	ry at	28d. Describe how i	niury occurred	
lal or Attending Physis safter death. I Director: After this c	Certification;	2 ☐ Accident investigation	Fnd 3/15/2006	nd 11:4	iOPM 1□	Yes 2∏No	unk		
or Att	ŧ	3 ☐ Suicide 6 ☑ Could not be determined	28e. Pface of Injury - At ho building, etc. (Specify	me, farm, sti ')	eet, factory, office		28f. Location (Stree City or Town, S	t and Number or Ru tate)	ural Route Number,
pital		29a. Certifier 1☐ Certifying Phy:	Unk	wladge doca	D occurred state :	ma data and -11	unk	-/-) d'-	4
To the Hospital or within 24 hours afte To the Funerel Dir completely filled in	edical	(Check only one)	sician: To the best of my knowner: On the basis of examinat and manner stated.	ion and/or in	vestigation, in my o	me, date and place opinion, death occu	e, and due to the caus urred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
To the Mithin To the	₩.	29b. Signature and title of certifier		4	29c. Licens	se number	29d.	Date signed (Monta	h, Day, Year)
) (arof H	allaund			ОСМ	E. Ma	ech 15	2006
		30. Name and address of person who co		23a) (Type,	Print)	Valle	E. E.M.	action in the depth of	MAA.
		CHLOCH. ALLAND			_111 H	Penn Stre	et Baltimo	ore, Mary	land 21201
St Regist	ate	31. Date filed (Month, Day, Year) MAR 2. 1 2	32. Registrar's Signat	ture	houles				SHIP CONTRACTOR AND

State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 3-16-2006 Year **Physician** Callis Clifton 12:30 A^M /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Mariner Health at Glen Burnie Glen Burnie Anne Arundel Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2 □ F 91 11-23-1914 Director 216-14-0343 MD Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other then "natural", or iteme 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 21 No Directo Anne Arundel Brooklyn 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 652 Douglas Street 21225 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ŽXNo Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if teem 27 is marked other then "na eny injury or other traumatic event, the Madic once. Elementary/Secondary (0-12) College (1-4or 5+) Machinist Shipbuilder 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Julius Clifton Callis, Sr. Laura Dean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Nettie Callis 652 Douglas Street; Brooklyn, MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Qther (Specify) Cedar Hill Cemetery 3-20-2006 Brooklyn Park, MD 21. Signature of Funral Service Licen 22. Name and Address of Facility Singleton Funeral Home, PA 1 Second Ave SW; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY Physician /Medical Due to (or as a consequence of) Examiner CARDNIC ZUNG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine inding physician and use as the burial-transit COROLAPES A Box 68760, Physician/Medical Eniverier 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 🗆 Yes Completed DEGENETATIVE ARTHRITES 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 12156056 1 Yes 1 ☐ Yes 2 ☐ No 2-No Division of Vital within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of contified 29c. License number 29d. Date signed (Month, Day, Year) N. PATALINGTUG SR 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13721 PUTER BACTIMORE 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006

			1 - For State Registrar		f Maryland		artmen rtificat					Reg. No:	006	181	197
	Physici	an	Decedent's Name (First, Middle Decedent's Name (First, Middle		# 1 A		2				2. Date of Dea Month	ath Day	Year		of Death
	/Medic	_	ALBERT	AUGUST		= 2					MARCH	16	200		5 P M
	Examin	er	4a. Facility Name (If not institution HAR BDF					, -	Location				County of Dea		
ı			5. Social Security Number		7. Age (In yrs. las.	t hirthday			MORE		R Date of Bird	1		re City	
	Funeral Director		219-16-2848	1 K M 2 □ F	7. Age (III yrs. 1as.	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da 12-1-1	y. Year) 9 1 9	MI	rthplace (State Country)	or r-oreign
			Usual Residence of Decedent		- 00						12 1 1				
	yland		10a. State 10b. County		10c. City, 1	own or Lo	ocation							10d. Inside	City Limits
	a Ma	ctor	MD Anne A	Arunde1	Gle	n Bur	nie							1 □ Ye	s 2 🔯 No
	라 다 6.728	Oire	10e. Street and Number				10f. Zip						en of What C	ountry?	
	death with the Maryland ms 23a or 28a-t ehow r must be notified at	Funeral Director	1572 Annapolis	T				1060				U.S.		-	
	er de	nne	11. Marital Status	Armed Fo		13.	Was Deced	lent of Hi orly Cuba	spanic Ori n, Mexicar	igin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	. 14	 Race - Am Black, Whi 	erican Indian, ite, etc.	
9	s aft	by F	1 Never Married 2 Mar 3 Widowed 4 Divorced	If Yes Giv	18		1 🗆 Yes	ZK No	Specify:			S	Specify:	white	
3-003p	thou sture		15. Deceden	it's Education		6a. Dece	dent's Usua	I Occupa	ation			16b. Kind	d of Business	s/Industry	
2	7 nin 7	pie	(Specify only highe Elementary/Secondary (0-12)	st grade completed) College (1	-40r 5+)	(Give	kind of wo	rk done d se retired	luring mos)	t of work	ing				
7	e filed within al Hygiene. I other than " vent, Ina Me	Completed	5	0011090 (1	10.017	E1e	ctric	ian				Cro	wn-Co	rk & Se	al Co.
2	d oth	Be	17. Father's Name (First, Middle,	,							(First, Middle,				
yland	Men	၉	Albert A. Clau		-						de B. D				
Mar	12 sh h and 7 ie m rraum	2.	19a. Informant's Name/Relations Mrs. Gloria Kii								Al Route Numbe				1
a) -	1 and Healt em 2		20a. Method of Disposition				PETIIC osition (Nan matory or o				; Glen			Town, State	
Baltimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. By any injury or other traumatic event, Ita Madical Examinat must be notified at Appea.		1XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State					3_2	1-2006			nie, MD	
	artme outan injur	1	21. Signature of Funeral Service		GIEII	-	2. Name an				ingleto:				
ă	Depa impo any ir	0 35	DINNER MU	Allus SI	460 110E	64 1	Seco	nd A	ve S		len Bur				
			23a. Part. Enter the disease, or shock, or heart failure. List	complications that controls one cause on e	aused the death.	Do not en	ter the mod	e of dying	g, such as	cardiac	or respiratory ar	rest,		Approxima	
	Physician		Immediate Cause (Final disease or condition		SPIRATI	اه ه	PNEL	MO	NIA					Onset and	d Death
	/Medical Examiner		resulting in death)		or as a consequer		. , , ,								7-
	cxammer		Sequentially list conditions,	b											
V	ed sit	niner	Sequentially list conditions, if any, reading to infinitediate cause. Enter Underlying Cause (Disease or injury that initiated events	2 000101	or as a consequen	ica ut):									
1	axecular and al-train	Examin	that initiated events resulting in death) Last	c. Due to (or as a consequer	ice of):									
/on,	death certificate be executed e attending physicien and od for use as the burial-transit	cail		d											11
9	tificat ig phy as the														
gox	th cer endin	an/N	IF FEMALE: 23b. Was decedent pregnant		come of pregnanci		∃Ectopic pr	ednancy				23	3d. Date of de		
	e dea he att	Physician/Med	in the past 12 months? 1 Yes 2 No		ant at time of deat		Other (sp						Month	Day	Year
л Э	d by t		9 ☐ Unknown Part II. Other significant conditi	one contribution to de	ath but not condition	ag in the u	a dachina a		n in Bort I		23e Did to	abacco un	o contributo I	to the cause of	I doeth?
as,	w requires that the death certifica teen signed by the attending pt should be detached for use as t	d by		FAILURE	saur but not resulti	ig in the c	indenying c	ause give	mirani			es 2.2	_	robably 4	
•	v requ	ete			EM ENTH						24a. Was				
ě	he law a hes b ige 2 sl	Completed	TICLETIV	ER 3 VE	ENT ENTIT	7					autop	rmed?	prior to death?		cause of
VITAL	sn: T	CO	25. Was case referred to medica						26 Place	of Deat	1 Yes		1 ∐ Ye:	s 20 No	
5	/sicie	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	npatient 2 EP	/Outpatie	nt 3 DC	A Othe			me 5□ Resid		Other (So	acifu)	
0	ig Phi ter thi		27. Manner of Death	28a. Date o		Bb. Time o		Bc. Injury Work	at		28d. Describe I	now injury	occurred		
Š	endin sath. or: Af	atio	2 - 7 100 100 111	gation		,	М		Yes 2□	No					
DIVISION	or Att Iter de Irect	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 289. Place	of Injury - At home ng, etc. (Specify)	, farm, st	reet, factory	, office			28f. Location (S City or Tox		Number or R	Rural Route Nu	ımber,
_	pital ours al		200 Continue Santa	na Obveleiana Taraha						1 1					
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: Attenthis certificate hes completely filled in by the funeral director, page 2 or	edicai	29a. Certifier fr Certifyii (Check only 2 Medical one)	ng Physician: To the Examiner: On the ba and mann	asis of examination	and/or in	n occurred ivestigation.	at the tim in my op	e, date ar pinion, dea	nd place, ith occuri	and due to the ed at the time,	cause(s) a date and p	nd manner a place, and du	s stated. e to the cause	n(s)
	ro the	Me	29b. Signature and title of certifie				290	. License	number	-		29d. Date	signed (Mon	th, Day, Year)	
			ly	MD				RE	500	0		MAR	CH 16	,2006	
	5		30. Name and address of person	who completed caus										,	
	<i>V</i>		LAY KH		1 501171	+ 1+	AMOU	ER!	ST, 1	3 MLT	MORE,	MD	212	25	
	Sta Registr		31. Date filed (Month, Day, Year,	2006 Page 1	egistrar's Signatur	ho	Me 1								
	ricgisti	er .	MAR 2 1	LUUU AND	Sala Da	100									

			1- State of Maryland / Department / Department / Departmen	artment of Health and Me tificate of Death	ental Hygier Reg.	1.000 00470
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia		William Robert Cook, Jr.	n	Month 15	PAK, 2006 9 30 A M
	/Medio Examin		4a, Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
4	Examin	eı.	Baltimore Washington Martial Conten	· Glan Bir	19k	Anna Armilel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
	Director		220-20-3686 ^{1⊠M 2□F} 77 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 2-22-1929	9 Country) MD
			Usual Residence of Decedent			
	ylan		10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
	Mar.	Director	MD Anne Arundel Glen Bur	nie		1 ☐ Yes 24⊒\$No
	r 28g	rec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	3a o	0	6503 Home Water Way	21061	1	U.S.A.
	death	Funeral		Was Decedent of Hispanic Origin? (Spec f Yes, specify Cuban, Mexican, Puerto R		14. Race - American Indian,
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is merked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	by Fur	1 ☐ Never Married 21乙 Married 11又 Yes 2 ☐ No	Tes, specify Cuban, Mexican, Puerto P	ucan, etc.)	Black, White, etc. Specify: white
Ö	2 hou	ed		dent's Usual Occupation	16b.	. Kind of Business/Industry
5	in 72	Completed	life. I	kind of work done during most of working DO NOT use retired)	g	
12	with ene.	mo	Elementary/Secondary (0-12) College (1-4or 5+) 12 Li	thographer		National Can
	filed Hyg other ant,		17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	den Sumame)
a	d be	To Be	William Robert Cook, Sr.	Evelyn M	largaret V	Valentine
2	houl d Me mark mati	Ĕ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailir	ng Address (Street and Number or Rural		
Maryland	d 2 s th an 7 is trau			2 Prince George St		
	1 an Heal am 2 thar		20a Method of Disposition 20b. Place of Dispo	sition (Name of Da		Location - City or Town, State
Ď	in it of or o		Burial 2 Cremation 3 Removal from State	natory or other place)	2006	
Ë	tmer tant tant			Veterans Cem 3-20-		rownsville, MD
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is merked other transary injury or other traumatic event, Ite Magnes.			Name and Address of Facility Sin Second Ave SW; G1		
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final	n pnlumo	will	Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as consequence of):			
	Examiner		Demen	7.9		
		Ē	Sequentially list conditions, Due to [or as a consequence of]:			
10/	ted nsit	nin	cause. Enter Underlying Cause (Disease or injury			
1,	cate be executed physician and s the burial-transit	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
8760,	be e iciar buris	alE				
87		dical	d			
×	death certific attending p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Вох	death certif e attending od for use as	Physician/M	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3	Ectopic pregnancy Other (specify)		Month Day Year
	0 0 0	/sic	1 Yes 2 No 9 Unknown	Jother (specify)		
P.0	requires that the een signed by th nould be detache	Ph	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I	23e. Did tobaco	to use contribute to the cause of death?
S,	8 50	by	the significant control to the same of the	nuonying oddae given in r dici.	1 ☐ Yes	2 No 3 Probably 4 Unknown
0.0	w require been signature	ted	- + X /		1 163	2200
Records,	~ Q 10	Completed	U		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
~	The law cate has page 2:	тo			performed	
ita	ician: Th certificate rector, pag	Be (25. Was case referred to medical	26. Place of Death	(Check only one)	
of Vital	iding Phyalcian: th. After this certifica	To	examiner? 1 Yes 2 No Hospital: 1 Nopatient 2 ER/Outpatier	at 3 DOA Other: 4 Nursing Hom	ne 5 🗆 Residence	6 Other (Specify)
0	g Ph ler th		27. Manner of Death 28a. Date of Injury 28b. Time of Injury (Month, Day Year) Injury		8d. Describe how in	
Division	Attending r death. ector: After by the fune	atio	1 SAatural 5 Pending (Month, Day Year) injury 2 ☐ Accident investigation	M 1 ☐ Yes 2 ☐ No		
Vis.	Atte	ifica	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office 2	8f. Location (Street City or Town, St	t and Number or Rural Route Number,
Ö	al or afte Dire	Certification:	4 Homicide Getermined building, etc. (Specify)		Only or Town, St	ato
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	aic	29a. Certifier Certifying Physician: To the best of my knowledge, death			
	e Ho 24 P Fu letely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurre	d at the time, date	and place, and due to the cause(s)
	vithlin o th	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	->-0) total	14006	03	115 2006
	1		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	().	2
	4		KOFI BURTEY, 301 +	tospital Dr	5	15minit, mD
	Sta	to.	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Regist		31. Date filed (Month, Day, Year) MAR 2. 1 2006 32. Registrar's Signature			
			MHU C I COOL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) 13 40 **Physician** 03 2006 /Medical 4c. County of Death Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE CITY OF SALTIMORE HOSPITAL If Under 24 Hrs. If Under 1 Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Year Social Security Number 6 Sax **Funeral** -68-3488 Days 1**X**M 2□F Months Hours Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or items 23s or 28s-f show or other treumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No by Funeral Director 10g. Citizen of What Country? 10e. Street and Number American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) NOMAS 11. Marital Status Black, White, etc. Yes 2 No Yes, Give ear or Dates: 1 Never Married Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced "natura!" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Pagas 1 and 2 should be filad within nent of Health and Mental Hygiene. int: if item 27 is marked other than " Elementary/Secondary (0-12) (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 ce 0/emap 7NOON 19b. Mailing Address (Street and Number or Rural Route Number, a. Informant's Name/Relationship (Type, Print) permit. Pagas 1 and 2 s Department of Health ar important: If item 27 is any injury or othar treu once. Method of Disposition easar Baltimore, Date Deurial 2 Cremation 3 Removal from State 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee leur Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) STAGE RENAL a. KND **Physician** ISRASA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events OMPLICATIONS OF Due to (or as a consequence of): Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit DEPSIS that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. OUNPLICHTIONS Completed by Physician/Medical the e use as i IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths?

1 Yes 2 No
9 Unknown Month Dav Year signed by the atte 4 Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 No ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After thi funeral of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident the within 24 hours after deal To the Funerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) pletely filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) M8 31204

Registrar DHMH 17 Rev 1/2001

State

e and address of person who

MAR 2 1

2006

31. Date filed (Month, Day, Year)

2401

peleted cause of death (ftem 23a) (Type, Print)

32 Registrar's Signature

			1_ For State	State of Maryland / D	Department of Health and N	•	_	18500
	hysici /Medio		Registrar 1. Decedent's Name (First, Middle, La Reginal d		Certificate of Death	2. Date of Death	•	3. Time of Death 6 12:34F M
ا ﴿	Examin			Medical Center		,	4c. County of Deal	timore
Di	ineral rector		5. Social Security Number 6. S 214-64-0358 1 Usual Residence of Decedent	du alle	hday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month Day, Ye	9. Bir	thplace (State or Foreign puntry) WY/MQ
1215-0036 within 72 hours after death with the Maryland ene.	8a-f show	ector	10a. State 10b. County	Ba	Itimore			10d. Inside City Limits 1 XYes 2 □ No
Jeath with t	ms 23a or 2 must be n	Funeral Director	10e. Street and Number 2402 Hal	YON AUCHU 12. Was Decedent Ever in U.S.	10f. Zip Code 2 2 2 4 13. Was Decedent of Hispanic Origin? (Sp		Citizen of What Co	
JU36	iral", or iter Examinat	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	lack
d 21215-0036 filed within 72 hours af Hygiene.	item 27 is marked other then "natural", or items 23s or 28s-f show other traumetic event. The Madical Examination to notified at	Completed	15. Decedent's Ed (Specify only highest grant properties) Elementary/Secondary (0-12)		Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	16b	Kind of Business/	Industry
yland 2 ould be filed Mental Hygi	rked other	To Be C	17. Father's Name (First, Middle, Last)	1000	18. Mother's Nam	e (First, Middle, Maid	den Sumame)	6
'e, Maryland 1 and 2 should be file Heelth and Mental Hy	n 27 is mai er traumet		19a. Informant's Name/Relationship	pe, Print) (Wife) 19b.	Mailing Address Street and Number or Rur	ral Route Number, Cit	ty or Town, State, 2	Tip Code)
Page Page	ortant: If Iter Injury or oth B.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specification)	temoval from State	Disposition (Name of , crematory or other place) 3/2	2/06 B	Location - City or	Town, State
Derrit.	eny In		21. Signature of Funeral Service Licer	ta M01363	Vaug	ene tre	NOTAL	Services 1217
	sician edical		Immediate Cause (Final disease or condition resulting in death)	UPPER GI BLE		or rèspiratory arrest,		Approximate Interval Between Onset and Death 48HDURS
	niner	er	Securation list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of SHOCK Due to (or as a consequence of				36HOURS
be executed	len and irial-transit	Exa	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	RESPIRATORY Due to (or as a consequence of			36HOURS	
c 68 / 60,	ng physic	Medical	IF FEMALE:	RENAL FAILUR	E	_		24HOURS
P.O. BOX 68 hat the death certifica	ed by the attending physicien and detached for use es the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delin Month	very Day Year
uires that	signed b	d by P	Part II. Other significant conditions of HEPATIC_CIRRHOSI		the underlying cause given in Part I.		o use contribute to	the cause of death?
	age 2 should	Completed by	ESOPHAGEAL VARIO			24a. Was an autopsy performed	24b. Were aut prior to o death?	opsy findings available ompletion of cause of
VII.	ector	Be	25. Was case referred to medical examiner?	ospital:	04	1 Yes 2 1	-	28 No
l or Attending Physician: after death.	r: Aller tris	ation; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 € patient 2 ☐ ER/Outp 28a. Date of Injury (Month, Day Year) 28b. Tir	Attent 30 DOA 4 Nursing Ho	me 5 ☐ Residence 28d. Describe how in		ıfy)
To the Hoepital or Attending Ph within 24 hours after death.	led in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)		28f. Location (Street City or Town, Sta	ate)	
To the Hoepital or within 24 hours after	eruna Metely fill	Medical	29a. Certifier Certifying Phyone) 2 Medical Exam	ician: To the best of my knowledge, ler: On the basis of examination and/ and manner stated.	death occurred at the time, date and place, a or investigation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
To the	dwoo	ž	29b. Signature and title of certifier		29c. License number DØØ63974	29d. C	Date signed (Month)	Day, Year)
3	Stat		30. Name and address of person who o	mpleted cause of death (Item 23a) (T	ACOMPANIES TO DESCRIPTIONS OF	TARYLAND	21204	

DHMH 17 Rev 1/2001

ORIGINAL